

# MENTAL HEALTH CARE: CAN VA STILL DELIVER?

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HEARING  
BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES SENATE  
ONE HUNDRED SEVENTH CONGRESS  
SECOND SESSION

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JULY 24, 2002

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## MENTAL HEALTH CARE: CAN VA STILL DELIVER?

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WEDNESDAY, JULY 24, 2002

U.S. SENATE,  
COMMITTEE ON VETERANS' AFFAIRS,  
*Washington, DC.*

The committee met, pursuant to notice, at 9:36 a.m., in room 418, Russell Senate Office Building, Hon. John D. Rockefeller IV (chairman of the committee) presiding.

Present: Senators Rockefeller, Jeffords, Wellstone, and Nelson.

Chairman ROCKEFELLER. Good morning, everyone. Senator Ben Nelson has to leave at 10, so I am going to make my statement, then I will ask him to make his and to ask any questions that he might want to ask.

In this committee, we have looked for some time at the quality of VA health care, and that is obviously our job. One of the facets of that is mental health care, which is broadly ignored in our country and broadly ignored by public policy. Today, we are going to discuss it in the Department of Veterans Affairs.

We debate quite a bit here in Congress. What we actually get done is questionable, but we certainly do debate. That debate about mental health and the parity of mental health has increased in its intensity. On the surface, there is parity for mental health care in the Department of Veterans Affairs. Veterans are technically not subjected to arbitrary limits on the number of visits to clinicians. So the foundation seems to be in place. But I worry that in actuality, VA may not be doing all it can to help those who are suffering.

Virtually all families in America face mental illness in one way or another. Veterans face it in higher proportions and more painfully in many cases. So my focus is simple: To make sure that VA is doing everything possible to guarantee that each and every veteran who needs mental health care, whether that is in the great State of Nebraska or the even greater State of West Virginia, or wherever it might be.

Why am I so adamant about this? Because so often, the battle wounds that veterans come home with are not visible. They may not be missing a limb. There may not be scars or shrapnel.

I have never seen anything as devastating as PTSD. Most Members of Congress could not tell you what the letters stand for, but the people that have PTSD suffer in ways which we are just beginning to understand. This does not have just to do with wars, but it has to do with life experiences too. But this is the Veterans' Committee, and we are talking about veterans and what they have

been through and, therefore, mental health has to be taken very, very seriously. So that is why I am adamant about mental health.

So we are talking about PTSD and mental health. It is not just a headache. It stays and it stays, and it can get worse. It has to be treated and has to be dealt with. Most of American society chooses not to admit that they have such things, and because of this they do not deal with them or do not know how to deal with them. But in the VA, we are meant to be able to address the problem.

VA has a long-term care health policy. The rest of the country does not; so we are ahead in theory. We have mental health parity; so we are ahead in theory. Are we ahead in fact? That is what this hearing is about.

Hypertension, heart disease affect so many people, but mental health is not far behind. Cancer and depression affect roughly the same number of veterans.

But is VA reaching all veterans who need care? VA's own Advisory Committee has in the past found that mental health services have not been maintained, per a congressional mandate. I just want to know what the facts are.

In my own State, a unilateral decision had been made to close the inpatient psychiatric unit at the Clarksburg VA hospital. That decision was made in spite of the fact that mental illness is one of the most prevalent diagnoses there. So, without an inpatient unit, veterans would have been required to leave their families and friends in the community and travel hours for care.

Whereas I am very happy to report the decision to close the psychiatric unit was reversed, I am very unhappy that it might have been closed. So, again, I fear that those needed inpatient programs are not being spared in other parts of the country.

Dr. Roswell, I know that managing a strong mental health network in times of overwhelming budget constraint is daunting. I said to you in your confirmation process, that yours is one of the world's toughest jobs. I am glad you are here and look forward to your testimony.

[The prepared statement of Chairman Rockefeller follows:]

PREPARED STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM  
WEST VIRGINIA

Good morning.

This Committee has looked at the quality of VA health care and the need for more to be done on long-term care. Today we will examine what I believe is just one more facet of veterans' health care—that of mental health.

Here in Congress, the debate continues about mental health parity. On the surface, there is parity for mental health care in VA. Veterans are technically not subjected to arbitrary limits on the number of visits to clinicians. But I worry that in actuality, VA may not be doing all it can to help those who are suffering.

My focus is simple—to make sure that VA is doing everything possible to guarantee that each and every veteran who needs mental health care—whether in West Virginia or Nebraska or Arkansas—is receiving that care.

Why am I so adamant about this? Because so often battle wounds do not manifest in physical illness, but in quiet and equally debilitating mental illness. These wounds are revealed as PTSD with effects that linger and symptoms that can be brought on years after combat.

While hypertension and heart disease afflict vast numbers of veterans, mental illness is not far behind. Cancer and depression affect roughly the same number of veterans.

But is VA reaching and treating all veterans who need care? VA's own Advisory Committee has in the past found that there is a lack of evidence that mental health services have been maintained—per a Congressional mandate. I hope to learn if this has improved.

In my own State, a unilateral decision had been made to close the inpatient psychiatric unit at the Clarksburg VA hospital. This decision was made in spite of the fact that mental illness is one of the most prevalent diagnoses there. Without an inpatient unit, veterans would be required to leave their families and friends in the community and travel several hours to reach the next available inpatient mental health bed.

While I am happy to report the decision to close the psychiatric unit was reversed—I fear that these needed inpatient programs are not being spared in other parts of the country.

Dr. Roswell, I know that managing a strong mental health network in times of budget constraints and a move toward primary care is not easy. As I told you at your confirmation hearing just four months ago, you would not have an easy job.

I welcome your testimony.

Senator NELSON. Thank you very much, Mr. Chairman. I appreciate the courtesy today. I have to preside at 10, so it gives me the opportunity to participate in still a meaningful way and fulfill my obligations.

First of all, I, Mr. Chairman, would like to submit my complete statement for the record, but to start by thanking the witnesses for being here today. As the Chairman said, yours is a daunting task with sometimes too few resources and too many requirements to be able to matching things, and in the area of mental health, that is obviously one of the things that you face today.

A review of the numbers indicate that veteran satisfaction with the mental health programs of the VA has declined by 15 percent and the VA is spending 23 percent less on these programs since 1996. I am not against spending less money if you are getting more results or you are achieving better results in the process, but a recent Federal study found that the Department's cost containment policies are having a profound impact on clinical practice, one of the most important areas of the VA, with a strikingly high number of VA staff psychiatrists across the country reporting that they do not feel that they have the freedom to prescribe anti-psychotic medicines of their choice for patients.

So Dr. Roswell, Mr. Secretary, in your view, do not these practices, particularly those that interfere with the physician's clinical judgment, actually increase the use of psychiatric hospital services, inpatient services, due to greater patient failure rates? Does this not further exacerbate the VA's capacity problems for veterans, and in some areas where there is not really any real capacity for this kind of inpatient care? I guess maybe I would like to have you respond to that.

Dr. ROSWELL. Thank you very much, Senator Nelson. You bring up some excellent points, and in general, I agree with you. We have been extremely challenged with growth in new veterans seeking care. Fortunately, most of the new users coming into our system today are veterans who do not have serious mental illness but rather have less serious problems that, while not as difficult to manage, do cause competition for very scarce resources.

We have had some reduction in staffing. We have been quite successful, based on clinical outcome measures, in shifting a variety of mental health services from an inpatient location to an outpatient delivery mode, but we have also distributed our delivery system

from a hospital-based system to a clinic-based system. What we have not yet been entirely successful with is being able to move the entire mental health team to a small satellite clinic.

So the 23 percent reduction you spoke of in resources, I believe, alludes to the number of mental health care staff working, particularly psychologists, as we have shifted a lot of programs. We are very resource- and staff-intensive on an inpatient basis to an outpatient basis, then distributed that outpatient care across not 165 hospitals, but over 1,200 locations of care. We have not been able to move those staff to those locations as effectively as we would like. We are working on that, and I will talk about telemedicine and some other plans we have to try to address that need later.

With regard to the anti-psychotic medications, I am a very strong advocate of atypical anti-psychotics. I have spoken on several occasions since my confirmation before this committee on the importance of using atypical anti-psychotics to enhance clinical outcomes. We have been adamant that there is no fail-first policy nor do we advocate a particular medication in management of mental illness, but rather defer that to a clinician's judgment.

Senator NELSON. It is strange, though, that the clinicians are now saying that they do not feel the freedom to prescribe what they feel and believe in their medical judgment would be the best prescription drug, and I think that is what raises questions, not that—I applaud your efforts to try to find a more effective and efficient way to treat these veterans, but if the clinicians raise questions about their ability to prescribe what they believe is the right kind of medication, how does that further advance good care? I do not want to suggest that they are always right. I do not think we ought to suggest that they are never right, either, so—

Dr. ROSWELL. No, I understand. I think there are two dimensions to the thorny question you pose. One is we have an obligation—and this is one of the strengths of the VA health care system—to provide the latest scientific evidence, side effect profiles, and efficacy studies on any medication to our clinicians. We can do that through our computerized patient record system.

So our challenge is to make sure that every clinician prescribing anti-psychotics has the latest information on their effectiveness, as well as their cost, what their side effects might be, and where they have a particular therapeutic advantage over a different medication. We have attempted to do that. If that is construed as constraining their practice, that is not the intent because it is intended only to be a guideline, a clinical practice guideline.

Senator NELSON. Can we get that word back to them so that they are not raising the question and they do then feel the freedom to make the prescriptions that they choose?

Dr. ROSWELL. I will certainly make sure that as I speak on the subject, which I do—I mean, it is a very important issue in my mind—that I continue to advocate for that and I will ensure through our Deputy Under Secretary for Operations and Management that there are no restrictions, once again, on any particular drug.

Senator NELSON. And if we find that there are continuing concerns, I assume it would be OK if we brought them to your attention.

Dr. ROSWELL. I would very much appreciate that.

Senator NELSON. I appreciate it.

Thank you very much, Mr. Chairman.

Chairman ROCKEFELLER. Thank you, Senator Nelson.

Senator NELSON. Thank you, Secretary.

Chairman ROCKEFELLER. Senator Wellstone?

Senator WELLSTONE. Thank you. I apologize, Mr. Chairman. I have to be at the floor in 10 minutes to speak about disaster relief and we have a markup in the Health Committee. I am going to try to come back. I am so interested in this testimony, and thank you for having this hearing.

Very quickly, a full statement in the record, please. Dr. Roswell, I am glad—on the Comprehensive Homeless Veterans' Assistance Act, we call upon each VA primary care facility to have a plan for dealing with the mental health services. Senator Rockefeller was talking about this. I cannot say I am 100 percent satisfied with the progress, but you have got it on the radar screen and I am glad you are moving in the right direction.

I will tell you what bothers me about the testimony here today is you basically have made a lot of cuts and put into effect a lot of savings in mental health services, but the most damning statistic I see in today's testimony is that only 17.8 percent reinvestment rate of the savings from the mental health services you put back into mental health for veterans, while the mental health services workload has increased 25 percent. That is completely unacceptable—unacceptable. That reinforces the very stigma that outrages me toward people who are struggling with mental health issues.

Now, I care a lot about Priority 7 veterans and a lot of this money, I think, has gone to them, but here is really the point. I do not think we should be cannibalizing the mental health and the substance abuse programs to use this to pay for other veterans. I do not think one group of veterans should be pitted against another group of veterans.

I do not think there should be a zero-sum game, and I would call on you, because I know you care about this, and I would call on the Secretary, whom I thoroughly enjoy working with, to come to us with a realistic budget that lets you do your mission, because you do not have that at all—at all. And for us, all of us here in the Senate, we are now back into deficits, and we can go over the tax cuts and all the rest. The only thing I am going to tell you is I am not prepared—I am not showboating here—I am not prepared to balance the budget on the back of veterans. That is the kind of budget that we are talking about here. It is unacceptable.

We have all worked too hard, yourself included, to overcome the stigma to basically—that is exactly what this budget is and that is exactly what is going on here, so we have got a lot of work to do, a lot of oversight, a lot of staying close to what is going on, Senator Rockefeller, and I want to be a part of that, believe me, you.

I am going to try to come back. I hate making a statement like that and then running out, but I am going to run back unless I cannot because of the markup in committee.

Chairman ROCKEFELLER. There are no doubts that you really care about this issue.

Senator WELLSTONE. Thank you.  
[The prepared statement of Senator Wellstone follows:]

PREPARED STATEMENT OF HON. PAUL WELLSTONE, U.S. SENATOR FROM MINNESOTA

Mr. Chairman, thank you for calling this hearing. Mental health parity is a critically important topic for me, both with regard to veterans and for Americans generally.

I've had a chance to review some of the written testimony and unfortunately it just seems to confirm that the Department of Veterans Affairs is increasingly losing ground in dealing with mental illness and substance abuse among veterans. It simply reinforces the testimony we heard last year when the Committee held hearings on homelessness among veterans—a majority of whom battle with mental illness—that veterans were not getting the mental health care that they needed.

As an aside, I would say to Dr. Roswell that you mentioned in your testimony some of the initial steps that VA is taking to be in compliance with provisions of the Comprehensive Homeless Veterans Assistance Act we passed last year that required each VA primary care facility to develop and carry out a plan for providing mental health services. I will have some questions for the record on VA's progress—but I'm glad that it's at least on the radar screen.

But back to my larger point—failure to provide veterans with adequate mental health services is especially unfortunate given that many veterans who struggle with mental illness—particularly those affected by PTSD—do so as a result of their service to their country. So if these veterans aren't getting the treatment that they need, it's just that much more of a scandal.

The testimony before us today suggests that the VA is essentially cannibalizing its mental health and substance abuse programs to pay for other veterans services. To me one of the most damning statistics from today's testimony is that there is only a 17.8% reinvestment rate of the savings from changes in mental health services back into mental health care for veterans. At the same time that the mental health service workload increased by 25%!

So either the VA has happened upon some kind of magic formula to dramatically reduce the cost of quality mental health care—in which case I hope they'll share it with us today—or the quality and accessibility of this care must be declining. Again, the testimony today suggests that it's the latter.

Most troubling is the charge that this decline in mental health and substance abuse services is occurring because veteran is being pitted against veteran within the VA in terms of what kind of care is delivered and which veterans are being served. We all know that the current challenge for the VA is to deal with dramatically rising demand especially among priority 7 veterans. This was also during a period where Congress and the Clinton administration—wrongly—were asking the VA to do more things with less money.

I don't think anyone's suggesting that these other services aren't worth while and important—it's not like it's just being frittered away. But it's telling that mental health services and substance abuse treatment seem to be bearing a significant brunt of the cost cutting.

The stigma against people with mental disorders has persisted throughout history, and it persists in the VA system as well. As a result, people with mental illness are often afraid to seek treatment for fear that they will not be able to receive help, a fear all too often realized when they encounter outright discrimination in health coverage. Why is it that because the illness is located in the brain, and not the heart or liver or stomach, that such stigma persists?

One of the most serious manifestations of stigma is reflected in the discriminatory ways in which mental health care is paid for in our health care system. We need to fix this problem in private insurance—which everyone on this committee knows of my interest in—and we need to ensure that veterans get decent mental health care.

In closing Mr. Chairman, let me say this: I don't think the VA should have to pit veteran against veteran and I don't think Congress should either. This shouldn't be a zero sum game. For the VA's part, I would say to Dr. Roswell, you need to come to us with a realistic budget that lets you do your mission.

For Congress's part: We know that now that were back into an era of deficits that Congress will have to make some hard choices. But I reject making them on the backs of veterans. We can find other places within the budget for savings or for sources of revenue.

Chairman ROCKEFELLER. Senator Jeffords?

Senator JEFFORDS. Thank you, Mr. Chairman. Thank you for holding this hearing.

The VA is in the right place to deliver this kind of care. It has some of the nation's top medical expertise and years of clinical experience and we appreciate that. Most importantly, the VA has the trust of the veterans and it is high time that the program was provided with the funding it needs and attention that it deserves and I intend to try to help you with that respect.

While we will not have time to focus specifically on PTSD treatment and research today, I would like to bring my colleagues' attention to the important contributions of VA's National Center for Post-Traumatic Stress Disorder. This center, headquartered in White River Junction, Vermont, is dedicated to improving the quality of VA treatment provided for veterans with PTSD.

The center's research, educational, and consultation services have unquestionably promoted better clinical treatment for veterans. The center has made significant contributions to our scientific understanding about the causes, diagnosis, and the treatment of this potentially incapacitating disorder that affects thousands of service-connected veterans, which you are well aware of.

The center has been innovative in its efforts to get information about PTSD into the hands of practitioners, who can put the information to good use with their patients. For example, the center has developed some unique resources for mental health professionals, such as an award-winning website and the largest and most comprehensive bibliographic data base in the world, called PILOTS, the Published International Literature on Traumatic Stress.

As a central authority on PTSD, the National Center has frequently served as a consultant to VA policymakers as well as other governmental and international officials on matters of concern in this area. The center has played an important role in developing practice guidelines for individual treatment and for early intervention in major disorders. Detailed information on the center is included in the latest annual report, which has been distributed to members of this committee.

I want to take this time today to acknowledge the important work of VA's National Center for PTSD. Strong support for this center is an important part of the effort to improve the VA mental health and improve treatments for our veterans.

Mr. Chairman, once again, I appreciate your holding this hearing today. I hope that these efforts will highlight the areas in which important improvements must be made and underline the critical importance of doing so immediately.

I apologize for not being able to stay for all the testimony, but I have another hearing I am in charge of that will take place shortly. Thank you very much, and thank you all for all you do.

Chairman ROCKEFELLER. Thank you, Senator Jeffords, very much.

I also want to mention, before I introduce the panel, that Senator Specter wanted to be here, but he has an absolute conflict. He regrets it. He specifically asked me to apologize to our panels, because he wants to be here but cannot.

Dr. Roswell, I have introduced you. You are accompanied by Dr. Larry Lehmann. Also testifying is Dr. Miklos Losonczy, who is the

Co-Chair of the Committee on Care of Veterans with Serious Mental Illness. We welcome you and await your testimony.

**STATEMENT OF HON. ROBERT H. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY LAURENT LEHMANN, M.D., CHIEF CONSULTANT, MENTAL HEALTH STRATEGIC HEALTH CARE GROUP**

Dr. ROSWELL. Thank you, Mr. Chairman. I appreciate your chairing the hearing today on VA's mental health programs. Our mental health clinical programs are designed to provide the highest quality, most cost-efficient care across a continuum of services designed to meet the complex and changing needs of our patients.

Last year, in fiscal year 2001, 886,000 veterans received mental health care and over 700,000 of them were treated in specialized mental health programs. VA expended over \$2.2 billion on clinical care for these patients and an additional \$375 million for psychotropic medications. VA has developed special emphasis programs designed to serve particular target populations, including veterans with serious mental illness, homeless veterans with mental illness, veterans suffering from post-traumatic stress disorder, and veterans with substance abuse problems.

VA has committed itself to expanding state-of-the-art treatment of serious mental illness using an assertive community treatment model and now operates the largest network of such programs in the country. Our Mental Health Intensive Case Management Program, or MHICM program, is an assertive community treatment model, and as of April of this year, VA had 65 active MHICM programs and several others in various stages of development.

As I have already alluded, VA is committed to using state-of-the-art medications, such as the new generation of atypical anti-psychotic medications, in treating seriously mentally ill veterans. Use of these medications results in improved clinical outcomes, a decreased incidence of side effects, increased compliance with the prescribed medication, improved functioning, and increased patient satisfaction, and no one supports their use more strongly than I do.

VA operates the largest national network of homeless outreach programs. VA's homeless programs serve not only homeless veterans, but they play a role in destigmatizing mental illness in the homeless population. Last December, the President signed P.L. 107-95, the Homeless Veterans Comprehensive Assistance Act of 2001, and this law was designed to enhance and increase VA's ability to serve the homeless veterans. I am happy to say that we are well on our way in our efforts to implement the provisions of that law.

Secretary Principi recently convened the first meeting of VA's Advisory Committee on Homelessness among veterans. The council will greatly assist VA in improving the effectiveness of our programs.

VA operates 147 specialized programs for the treatment of PTSD. In fiscal year 2001, VA's specialized outpatient PTSD programs saw over 57,000 veterans, an increase of 8.6 percent over the previous year. Overall, inpatient PTSD care is declining, while the alternative, residential care, is increasing. This reflects our commit-

ment to moving from costly inpatient programs to less costly but equally effective outpatient programs.

In 2001, VA treated 125,000 veterans in specialized substance abuse treatment programs. The number of veterans receiving inpatient care for substance abuse is decreasing, as a part due to the shift to outpatient care. To accommodate for this shift, services are increasingly being developed on a residential and outpatient basis. In 2001, VA saw a 9.5 percent decrease in the number of veterans treated in its in-house specialized substance abuse programs, but at the same time, a number of networks instituted contracts for residential substance abuse treatment services. Consequently, VA has begun a process to determine where these veterans are now being treated and the adequacy of the treatment in residential settings.

Section 8(a) of P.L. 107-95 requires VA health care facilities to develop and carry out plans to provide mental health services for substance abuse disorders and VA is fully prepared to implement those plans this year with quarterly monitoring.

Our educational programs are significant. VA's educational programs involve traditional programs, and recently, VA developed an innovative psychiatry resident primary care education model to enhance the educational effort.

Our research programs encompass both basic science as well as essential scientific findings. VA's Mental Illness Research, Education, and Clinical Centers, or MIRECC's, are excellent examples of the fusion of these three tasks. Currently, VA has eight MIRECC's located all across the country.

Perhaps the most exciting aspect of VA's mental health programs as we look to the future is its National Mental Health Improvement Plan, which uses validated data collection, expert analysis, and active intervention by an oversight team to continuously improve the access, outcomes, and function of mental health patients.

Mr. Chairman, our mental health system is strong and effective, but no system is perfect. Quality improvement activities, such as the National Mental Health Improvement Plan, symbolize VA's commitment to continuing improvement in the delivery of comprehensive, high-quality care. It is imperative that high-quality mental health services be available across the VA health care system and we are committed to that. Mr. Chairman, thank you.

Chairman ROCKEFELLER. Thank you, Dr. Roswell.

[The prepared statement of Dr. Roswell follows:]

PREPARED STATEMENT OF HON. ROBERT H. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee:

The Department of Veterans Affairs (VA) provides mental health services for veterans across a continuum of care, from intensive inpatient mental health units for acutely ill persons to residential care settings, outpatient clinics, day hospital and day treatment programs, community-based outpatient clinics (CBOCs), and intensive community case management programs. VA views mental health as an essential component of overall health and offers comprehensive mental health services, including programs for substance abuse, as part of its basic benefits package.

In FY 2001, VHA saw 4,153,719 patients for all health care services; 886,019 (21.3 percent) of these received mental health care. Of those who received mental health care, 712,045 veterans were treated in specialized mental health programs. The remaining 173,974 received mental health care in general medical care settings. Of the overall total number of patients receiving mental health care, 285,161 met cri-

teria for inclusion in the Capacity Report, i.e., an inpatient admission or six or more outpatient visits.

The 712,045 unique veterans treated in specialized mental health programs represent a 4.9 percent increase from the previous year, over four times the increase for the period from FY 1999 to FY 2000. Only 10.1 percent of these patients required an inpatient stay, demonstrating VA's emphasis on providing care in the least restrictive, most accessible way that meets patients' needs, which includes enhancing our capability to provide mental health services in CBOCs. Over 85 percent of veterans who use VA mental health services are in Priority Groups 1–6, our "core mission" patients. The clinical care costs for specialized mental health services in FY 2001 were approximately \$2,400,000,000. For FY 2002, it is estimated that VA will provide care in mental health programs to 729,400 unique patients at a cost of more than \$2,484,000,000.

The clinical care costs mentioned above cover major expenses such as staffing, but do not include the costs of psychotropic medications. Pharmacy costs for psychotropic medications in FY 2001 were \$375,117,569, an increase from \$304,696,503 in FY 2000. The figure for FY 2001 includes prescriptions for both patients who were treated in specialty mental health services and patients who received care from non-specialty providers such as primary care clinicians.

This statement describes VA's mental health clinical services, education and research initiatives, program monitoring efforts, and special programs for homeless veterans.

#### CLINICAL CARE SERVICES

Treatment for mental illnesses in VA rests essentially on two main approaches, pharmacotherapy and psychosocial rehabilitation (including psychotherapy). It is our practice to provide the latest medications for mental disorders to veterans who need these drugs and to prescribe them in accordance with the best medical evidence. VA's formulary for psychotropic medications is one of the most open in organized health care. It includes virtually all of the newer atypical antipsychotic and anti-depressant drugs.

In most cases, medications alone are not enough to bring patients with serious mental illnesses to their optimal level of functioning and well-being. The application of psychosocial rehabilitation techniques, designed to optimize patients' strengths and promote recovery, is essential. These interventions include patient and family education, cognitive behavioral therapy, working and living skills training, and intensive case management. Treatment is provided in both inpatient and outpatient settings and can include supervised living arrangements in the community.

Assisting veterans to engage in meaningful and productive work activities is an important part of their therapeutic rehabilitation. VHA accomplishes this primarily through the Compensated Work Therapy (CWT) program and Compensated Work Therapy/Transitional Residence (CWT/TR) program.

In FY 2001, 22,053 veterans had contact with the CWT program and 13,700 worked through the program. There currently are more than 105 individual CWT operations connected to VA medical centers nationwide. Through CWT programs with companies and government agencies, veterans earned \$33.4 million.

The CWT/TR program includes 34 sites at 26 currently operational programs with 55 residences and 433 operational beds in FY 2001. Nine program sites with 17 residences are designated to exclusively serve homeless veterans. The average length of stay is approximately six months. Increased competitive therapeutic work opportunities are occurring each year. At discharge from the CWT/TR program, 41 percent of the veterans were placed in competitive employment and four percent were in training programs.

Additionally, VHA offers a vocationally oriented program, the Incentive Therapy (IT) program. Veterans working in IT provide direct services to VA Medical Centers, for which they receive remuneration. Such work is done usually in preparation for transfer to CWT, or direct job placement. In FY 2001, 8,806 veterans were served by IT. Some stations sponsor Incentive Therapy On the Job Training programs (IT/OJT) in which veterans learn vocational skills while providing services to the host Medical Center. The IT program operates at over 80 Medical Centers.

VA's clinical services are increasingly being structured to accommodate mental health participation in medical and geriatric primary care teams and medical capabilities in mental health primary care teams. Best practice models have been identified in the field based on criteria that included patient clinical improvement, prevention, screening activities, and patient satisfaction. We have data showing that when medical primary care services are integrated with mental health care, clinical

outcomes, as measured by standard VA indicators (e.g., Preventive Disease and Chronic Disease Indices), are improved, as is patient satisfaction.

Section 8(a) of Public Law 107-95 requires that each VA primary care health care facility develop and carry out a plan to provide mental health services, either through referral or direct provision of services. Section 8(c) also requires that each VA medical center develop and carry out a plan to provide treatment for substance use disorders, either through referral or direct provision of services. Treatment for substance abuse disorders is to include opioid substitution therapy, where appropriate. In the first two quarters of FY 2002, all VISNs prepared plans to implement this section of the law. VHA HQ has approved all plans and is monitoring their implementation quarterly.

Innovative uses of technology such as tele-mental health are also being implemented to enhance mental health services to distant sites (e.g., CBOCs) and provide psychiatry support to Veterans Outreach Centers. In addition there are 10 tele-mental health demonstration projects either operational or in development. By disseminating information about best practices across the system, program development is encouraged, and higher quality, more cost-efficient care will be delivered to VA patients.

#### MENTAL HEALTH SPECIAL EMPHASIS PROGRAMS

VA has identified several particular target populations and has developed special emphasis programs designed to serve those populations. They include veterans with serious mental illness (e.g., those suffering from schizophrenia and other psychoses); homeless veterans with mental illness; veterans suffering from Post-traumatic Stress Disorder (PTSD); and those with substance abuse disorders. A significant percentage of all veterans receiving mental health services are seen in the following special emphasis programs.

##### *Serious Mental Illness*

Since 1996, the number of veterans seen with serious mental illness has increased by six percent while the cost has increased by four percent, reflecting decreased hospital days of care counterbalanced by increased spending on outpatient care. The average length of stay for general inpatient psychiatry decreased from 29.9 to 17.0 days nationally, and the average number of days of hospitalization within six months after discharge (reflecting readmissions) dropped from 12.4 to 6.7. The percent of discharged general psychiatry patients receiving outpatient care within 30 days of their discharge has increased from 50 percent in FY 1996 to 59 percent in FY 2001. These indicators suggest more effective hospital treatment and aftercare, including intensive case management services. A 17 percent decrease in the number of general psychiatric patients hospitalized in FY 2001 compared to FY 1996 was accompanied by a 29 percent increase in general psychiatric patients receiving specialized mental health outpatient care, resulting in a net 28 percent increase in individual veterans treated in specialty mental health. These data suggest an effective move from inpatient to community-based mental health treatment nationwide.

VA has committed itself to expanding state-of-the-art treatments of serious mental illness, using the Assertive Community Treatment (ACT) model. VA now operates one of the largest networks of such programs in the country, the Mental Health Intensive Case Management (MHICM) program. As of April 2002, VA had 65 active MHICM programs with another 10-12 in various stages of development, a 33 percent increase in this fiscal year alone. VISN plans for expansion of MHICM teams are reviewed quarterly.

Another aspect of VA's care for veterans with seriously mental illness is our commitment to using state-of-the-art medications, which result in improved clinical outcomes, decreased incidence of side effects, and increased compliance with prescribed medications. Patient functioning and patient satisfaction are increased. In FY 2001, of the 78,210 veterans with a diagnosis of schizophrenia who received antipsychotic medications, 72 percent received the new generation of atypical antipsychotic medications, such as olanzapine, clozapine, risperidone, quetiapine, or ziprasidone.

##### *Homeless Veterans*

VA operates the largest national network of homeless outreach programs. VA expects to spend \$144 million on specialized programs for homeless veterans this year. In FY 2001, VA initiated outreach contact with 44,845 veterans. VA's Health Care for Homeless Veterans (HCHV) program incorporates:

- outreach to serve veterans with serious mental illness who are not currently patients at VA health care facilities;

- linkage with services such as VA mental health and medical care programs, contracted residential treatment in community-based halfway houses, and supported housing arrangements in transitional or permanent apartments; and
- treatment and rehabilitation provided directly by program staff.

These activities serve not only to help homeless veterans; they play a role in destigmatizing mental illness in the homeless population.

Secretary Principi recently convened the first meeting of VA's Advisory Council on Homelessness Among Veterans. The Council's mission is to provide advice and make recommendations on the nature and scope of programs and services within VA. This Council will greatly assist VA in improving the effectiveness of our programs and will allow a strong voice to be heard within the Department from those who work closely with us in providing service to these veterans.

#### *Post-Traumatic Stress Disorder*

VA operates an internationally recognized network of 147 specialized programs for the treatment of PTSD through its medical centers and clinics. This figure includes new specialized programs funded by the Veterans Millennium Health Care and Benefits Act that are operational and seeing new patients. In FY 2001, VA Specialized Outpatient PTSD Programs (SOPPs) saw 57,783 veterans, an increase of 8.6 percent over the previous year. Of these, the number of new veterans seen was 23,082. For SOPPs, continuity of care, measured as number of visits across 2-month intervals (a marker for quality of care), was maintained between FY 2000 and 2001.

Specialized Inpatient and Residential PTSD Programs had 5,012 admissions in FY 2001. Overall inpatient PTSD care is declining while the alternative, residential care, is increasing. Outcomes for outpatient PTSD treatment (e.g., continuity of care) and for Specialized Inpatient PTSD Programs (e.g., PTSD symptoms at four months post discharge) were maintained or improved in FY 2001 over FY 2000.

These specialized Mental Health PTSD programs act in collaboration with VA's 206 Vets Centers, which are community-based operations staffed by a corps of mental health professionals, most of whom have seen active military service, including combat.

#### *Substance Abuse*

In FY 2001, 429,032 VA patients had a substance use disorder diagnosis. Of these, 125,660 were seen in specialized substance abuse treatment programs. Most of the rest of these veterans were seen in non-substance abuse mental health care settings or received non-mental health services. The number of veterans receiving inpatient care for substance use disorders is decreasing, as part of the shift to outpatient care. Studies show that for many patients residential and outpatient substance abuse treatment can be as effective as inpatient services. To accommodate this shift, services are increasingly being developed on a residential and outpatient basis. From FY 2000 to 2001, VA saw a 9.5 percent decrease in the number of veterans treated in its in-house specialized substance abuse programs. At the same time, a number of networks instituted contracts for residential substance abuse treatment services. Consequently, VA has begun a process to determine where these veterans are now being treated and the adequacy of that treatment. As of January 2002, in the 31 new Substance Abuse programs established to implement the requirements of § 116 of Public Law 106-117, 1500 additional patients had been seen. VHA is also reviewing its capacity to provide opiate substitution services and the need to expand these services.

#### MAINTAINING CAPACITY

Under 38 U.S.C. § 1706(b), VA is required to maintain its capacity to meet the specialized treatment and rehabilitative needs of certain disabled veterans whose needs can be uniquely met by VA. Mental health encompasses four of the designated populations, veterans with severe, chronic mental illness, veterans suffering from post-traumatic stress disorder (PTSD), homeless veterans with mental illness, and veterans with substance abuse disorders.

From FY 1996 to FY 2001, VA has maintained or increased capacity to treat veterans in both the SMI and PTSD categories in terms of patients served. Although overall capacity has increased, there has been a decrease in the number of veterans with substance abuse who meet SMI criteria and were served in specialized programs by the system as a whole, from 105,898 in FY 1996 to 89,963 in FY 2001. The Networks completed an initial review of variation in April 2002, the results of which are being analyzed. Based on this ongoing analysis, VHA will identify areas for improvement. Several performance monitors are in place to ensure our ability to maintain capacity to treat specialized mental health disorders.

## PROGRAM MONITORING

To track its progress and enhance its performance in mental health services, VA has one of the most sophisticated mental health performance monitoring systems in the nation. To monitor the care provided in mental health programs to over 700,000 veterans per year, VA uses measures of performance, quality, satisfaction, cost, and outcomes (e.g. PTSD symptoms; homeless veterans who are domiciled). The results published annually in VA's National Mental Health Performance Monitoring System report indicate that quality of care, as indicated by performance monitors associated with quality and patient satisfaction, is essentially being maintained or is improving. Lengths of inpatient stay (LOS) have increased slightly from 16.6 days in FY 2000 to 17.0 in 2001, but there has been an overall 39 percent decrease in LOS since FY 1995. Readmission rates and days hospitalized after discharge decreased slightly from FY 2000 to FY 2001. There have been slight decreases in measures of outpatient care in the past year, mostly by less than four percent. However, the number of outpatient visits is down by 8.5 percent, from 17.2 to 15.7 average visits per year for general psychiatry patients.

The Seriously Mentally Ill Treatment Research and Evaluation Center (SMITREC) created a Psychosis Registry, a listing of all veterans hospitalized for a psychotic disorder since 1988. This registry tracks the health care utilization of these veterans over time. Over 70 percent of these veterans are still in VA care. The percentage of patients with long inpatient stays (over 100 days) is decreasing while the number of patients receiving atypical antipsychotic medications has increased. SMITREC is studying aspects of patients' adherence to treatment regimens, a key element in maintaining patients in the community with optimal good health.

To support its mental health programs and to ensure acquisition of the most current knowledge and dissemination of best practices, VA has undertaken a number of activities. These include development of practice guidelines, educational programs, and partnering with other organizations involved in mental health services.

VHA has also published up-to-date, evidence-based practice guidelines for major depressive disorders, psychoses, PTSD, and substance use disorders. The International Society for Traumatic Stress Studies used VA's initial PTSD guidelines as a start for their guideline development. Earlier this month, work started on a new stand-alone VA/DOD PTSD Clinical Practice Guideline. The Major Depression guidelines, revised in collaboration with the Department of Defense (DOD), were published in FY 2001. A new "stand-alone" Substance Abuse guideline created with DOD has been published, and the revised Psychoses Guidelines are currently in review. Automated clinical reminders are in development to assist clinicians in following the practice guidelines and document and track compliance.

Last year, MHSHG inaugurated a new quality improvement program - the National Mental Health Improvement Program (NMHIP). NMHIP uses validated data collection, expert analysis, and active intervention by an oversight team to continuously improve the access, outcomes, and function of patients in need of our mental health programs. The program draws upon existing MHSHG resources such as the Northeast Program Evaluation Center (NEPEC), and the Mental Illness Research, Education and Clinical Centers (MIRECCs), as well as resources in VHA's Health Services Research and Development Service, including existing initiatives in the Quality Enhancement Research Initiative (QUERI), and the Office of Quality and Performance. Currently NMHIP is reviewing general assessment measures for patients with mental disorders, focusing on the Global Assessment of Functioning Scale (GAF) and the SF-36 functional status survey instrument. NMHIP is also beginning to look at diagnosis-specific assessment tools starting with those for schizophrenia.

## EDUCATION

VA has been a leader in the training of health care professionals since the end of World War II. More than 1,300 trainees in psychiatry, psychology, social work, and nursing receive all or part of their clinical education in VA mental health programs each year. Recently, VA has developed an innovative Psychiatry Resident Primary Care Education program with involvement of over thirty facilities and their affiliates, representing approximately 11 percent of VA's more than 700 psychiatry residents who receive training in VA facilities each year. In addition, 100 psychology and psychiatry trainees are involved in the highly successful Primary Care Education (PRIME) initiative, which provides mental health training within a primary care setting. This type of activity is changing how VA is training mental health providers and preparing them to meet the primary care needs of mentally ill patients. It serves and improves the mental health of veterans seen in medical and geriatric primary care in both VA and the nation.

In addition, VHA's Office of Academic Affiliations, in collaboration with the Mental Health Strategic Health Care Group and the Committee on Care of Seriously, Chronically Mentally Ill Veterans, has recently introduced a new interdisciplinary fellowship program in Psychosocial Rehabilitation. This program will train fellows from Psychiatry, Psychology, Social Work, Mental Health Nursing, and Rehabilitation in the latest state of the art approaches to treating and reintegrating those with serious mental illnesses into the community.

VA's educational efforts involve both traditional programs and innovative distance learning techniques. Face-to-face workshops serve a useful purpose for certain kinds of demonstrations (e.g., Prevention and Management of Disturbed Behavior Training) and for networking. Distance learning such as satellite broadcasts, Internet training, and teleconferencing, offers accessible, cost-effective training.

#### RESEARCH

VA's National Center for PTSD, established in 1989, is a leader in research on PTSD. Its work spans the neurobiological, psychological and physiological aspects of this disorder. Women's sexual trauma and mental health aspects of disaster management are also addressed by the National Center, which has become an international resource on psychological trauma issues.

VA's Mental Illness Research, Education and Clinical Centers (MIRECCs), which began in October 1997, bring together research, education, and clinical care to provide advanced scientific knowledge on evaluation and treatment of mental illness. The MIRECCs demonstrate that the coordination of research with training health care professionals in an environment that provides care and values results in improved models of clinical services for individuals suffering from mental illness. Furthermore, they generate new knowledge about the causes and treatments of mental disorders. All of the MIRECCs have active projects that are of direct benefit to veterans. In order to help create a new generation of mental health scientists, the MIRECCs, with the support of the Office of Academic Affiliations, have established Special Mental Health Fellowships to train young psychiatrists and psychologists for research careers. Their videoconference curriculum is accessible by non-MIRECC VA trainees as well. VA currently has eight MIRECCs located across the country, from New England to Southern California.

Mental health currently has two projects in the VHA Quality Enhancement Research Institutions (QUERI) program. These include the Substance Abuse QUERI project, associated with the Program Evaluation Resource Center (PERC), and the Mental Health QUERI project. The Mental Health QUERI actually has two sets of activities: the Major Depression QUERI associated with the VISN 16 MIRECC, and the Schizophrenia QUERI associated with the VISN 22 MIRECC. The goal of QUERI is to promote the translation of research findings into practice and observe their impact on quality of care.

VHA has established an interagency Memorandum of Agreement (MOA) with the Substance Abuse and Mental Health Services Administration (SAMHSA) and Bureau of Primary Health Care (BPHC) of the Health Resources and Services Administration (HRSA). This MOA will support a cross-cutting initiative to determine if there are statistically significant differences over a full range of access, clinical, functional, and cost variables between primary care clinics that refer elderly patients to specialty mental health or substance abuse services (MH/SA) outside the primary care setting and those that provide such services in an integrated fashion within the primary care setting. It will also address improving the knowledge base of primary health care providers to recognize MH/SA problems in older adults.

VA is also a partner with the National Institutes of Mental Health and the DOD in the National Collaborative Study of Early Psychosis and Suicide (NCSEPs). This ongoing project is designed to better understand the clinical and administrative issues of service members who suffer from psychotic disorders during military service, their course of care, and the transition from DOD to VA care in such a manner that continuity of care is maintained.

In FY 2001, VA Research Service funded 379 mental health projects at a cost of \$53,756,149. VA investigators also were awarded \$131,600,314 from other sources that funded an additional 1,189 mental health projects.

#### CONCLUSION

VA Mental Health programs provide a comprehensive array of clinical, educational and research activities to serve America's veterans. Our clinical programs are designed to provide the highest quality, most cost-efficient care, across a continuum of care designed to meet the complex and changing needs of our patients. Our educational programs train a significant proportion of our nation's future men-

tal health care providers and ensure that our employees remain on the cutting edge of knowledge about the best clinical practices using traditional as well as innovative educational approaches. Our mental health research programs encompass both basic science as well as the essential translation of scientific findings into clinical practice. The Mental Illness Research Education and Clinical Centers (MIRECCs) are excellent examples of the creative fusion of all three of these tasks.

Mr. Chairman, our mental health care system is strong and effective, but no system is perfect. Quality improvement activities such as NHMIP and QUERI symbolize VA's ongoing commitment to continuing improvement in the delivery of comprehensive, high quality clinical services to those veterans who need our care. It is imperative that high quality mental health services be available across the VA health care system. We are continuing our efforts to assure availability of appropriate services and the implementation of evidence-based practices in real world clinical settings.

Mr. Chairman, I will now be happy to answer any questions that you or other members of the committee may have.

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RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV  
TO ROBERT H. ROSWELL, M.D.

*Question 1.* VA is embarking on an expedited effort to restructure and realign how VA delivers services—the CARES effort. How will the CARES process take into account the needs of the seriously mentally ill, now and in the future?

Answer. The CARES process is dedicated to providing a framework for identifying and addressing the needs of veterans in the future through the development of market-specific planning initiatives for the next 20 years. The needs of veterans who are users of VA mental health care, especially those with serious mental illness, are incorporated and considered in the planning model at several levels. First, veterans with mental disorders are being considered in the enrollment pool of veterans as projected into the future. Many veterans use VA mental health services because non-VA mental health resources, especially public mental health resources, may be lacking in their communities. This can be particularly true for conditions where VA has unique expertise such as war zone related PTSD or co-morbidity of substance abuse disorders with other mental disorders. Second, since these veterans, especially those with Serious Mental Illness (SMI) tend to rely heavily on the VA for all of their health care needs; this reliance is factored into the model in predicting utilization. Third, the current inpatient and outpatient utilization of veterans with serious mental disorders is being used to predict future needs for services. Also, the projections of future needs are adjusted, using diagnosis-based methods, to reflect the fact that veterans tend to have greater episodes of illness than private sector health care users. Finally, the basic planning categories for the CARES process include both inpatient and outpatient treatment provided by multidisciplinary teams including psychiatrists, psychologists, and other mental health providers. Moreover, prior to approval, the draft CARES plan will be reviewed by a group of clinical experts in health care, including mental health clinicians, and by the CARES Commission, to ensure that the criteria of health care needs and quality of care are met.

*Question 2.* As discussed in the hearing, please develop, together with the Committee on Care of Veterans with Serious Mental Illness, a budget estimate of the costs to fully fund on a national level a complete comprehensive continuum of care for veterans with serious mental illness, including PTSD and Substance Abuse Disorder. This continuum of care, as discussed at the hearing, should specifically include elements that would provide all aspects needed for optimal rehabilitation for these veterans. This should include those programs needed to fully address work restoration, supported housing, family supports, access to Community Based Outpatient Clinics where feasible, and Mental Health Intensive Case Management (MHICM) programs for all veterans needing these services. This estimate should also take into account the geographic challenges to serving the SMI population, and where it would not be reasonable to have a full MHICM team, a comparable program with similar intensity of treatment and rehabilitation should be estimated. In addition, this continuum of care should also include complete substance use disorder treatment, including opioid substitution treatment where necessary. Such estimates should be provided by VISN and program type. We understand that these are estimates only to give us insight into the approximate funding that would be needed for full implementation of addressing the unmet needs of these disabled veterans. For the purposes of this estimate, please use the SMI population defined in the FY2001 capacity report, as your current drafts may indicate. Please provide a response to this Committee no later than November 1, 2002.

Answer. The President's FY 2004 Budget will be the Administration's plan to support the medical care needs of all veterans, including their mental health requirements. This budget will be submitted to the Congress the first week of February 2003. While final decisions of the FY 04 budget are still to be made, we will work closely with OMB to assure that this budget will be adequate to deliver the defined benefit package of health care to all enrolled veterans, especially those that are service connected, medically indigent, and those with special needs. I understand and share your particular interest in mental health. It is my responsibility as Under Secretary for Health to insure the capability of the Veterans Health Care program to provide a balanced and complete comprehensive range of services to all enrolled veterans.

The Mental Health Strategic Health Care Group (MHSHG) is continuing to work closely with the SMI Committee to respond to your question. The group has been working since August to provide an analysis of potential gaps in services, best practices and programs, and their respective costs. As you can imagine, this is a very complex process. The MHSHG has now received the SMI Committee's recommendations and those are currently under review. VHA is engaging the services of an external contracting group with experience in healthcare management modeling to verify VHA's analyses of the mental health population's service requirements as described in their report. Completion of the review is expected early next year.

We will, of course, need to reconcile these plans with the final budget approved by Congress and the Administration. We would anticipate that our final response will be available February 2003.

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RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. ARLEN SPECTER TO ROBERT H. ROSWELL, M.D.

*Question 1a.* I am advised that—as is the case with respect to other forms of VA health care—treatment of mentally ill veterans has shifted from a predominately inpatient to a predominately outpatient setting. I am told that in Pennsylvania, for example, inpatient psychiatric beds have been reduced by over 60%—from 884 (in 1996) to 334 (in 2002). Is this correct?

Answer. VISN 4 facilities have decreased psychiatry beds from 884 in FY 1996 to 344 in FY 2001 for a decrease of 61 percent. Within Pennsylvania, the decrease was from 616 beds to 252 beds (a 59 percent decline). Alternatives to inpatient psychiatry beds have produced an increase in domiciliary beds for homeless veterans (up 69.6 percent from 115 to 195 beds), all of which are in Pennsylvania. Homeless Grant and Per Diem beds, Community Residential Care beds on medical center grounds and Health Care for the Mentally Ill (HCMI) beds have increased from 0 such beds in FY 1996 to 258 in FY 2002, all of which are in Pennsylvania. Specific efforts have been made to develop these alternative levels of care, some of which are community-based, others of which remain on medical center grounds. VISN 4 plans to conduct a needs assessment for acute psychiatry beds, as well as evaluate the need for additional residential and/or general domiciliary beds. The cost for establishing a geropsychiatry brief evaluation and treatment unit will also be evaluated.

*Question 1b.* To what do you attribute this drop in the overall number of inpatient psychiatric beds? Do fewer veterans need mental health services from VA? Or are you treating a more-or-less constant need in different settings?

Answer. For the most part, the 67 percent decrease in the average daily census of VA psychiatric hospital bed sections since 1983 has paralleled or, at times, lagged behind the trends in both private and non-VA public sector mental health care. The roots of this shift go as far back as the Community Mental Health legislation of the mid-1950s, when the concept that patients with a mental illness were best managed in isolated asylums was challenged by evidence that, with new antipsychotic medications, patients who had been hospitalized for decades could now recover sufficiently to go home. Long-term studies of patients with schizophrenia in the 1980s revealed that many patients recover with time and most improve to the extent that they can engage again in their life's progression. As the psychotropic medications have progressively improved over the years, the need for long-term hospitalization has progressively diminished.

This is particularly true with the recent advent of newer antipsychotic medications with less severe side effects. These medications also permitted patients to engage in progressively more sophisticated psychosocial approaches in the community, including assertive community treatments, work programs with supported employment, and newer rehabilitation concepts that promote self care and improved self-esteem.

Currently, the empirical literature supports treating those with serious mental illnesses in the least restrictive environment with the full spectrum of community oriented psychosocial rehabilitation treatments, including psychotropic medications. This is designed to assist those with serious mental illness to achieve the maximum functional recovery so that they can attain the highest level of functioning possible. VA's outpatient and residential psychosocial rehabilitation programs are designed to do this, and treatment in an inpatient setting is used sparingly and only when needed.

Thus, clearly, fewer veterans need inpatient services from VA. However, while the number of veterans requiring at least some hospital care dropped 60 percent (from 180,408 in 1996 to 72,252 in 2001), the number of veterans needing mental health services from VA has increased 22 percent, from 581,624 in 1996 to 712,045 in 2001, primarily in the outpatient arena.

*Question 1c.* Has a reduction in the number of psychiatric care beds resulted from a decrease in the need for inpatient services? Or has the reduction in the number of patients being treated in an inpatient setting been driven by budget-driven bed closures?

Answer. It is clear that the need for psychiatric beds has been drastically reduced. Both the VHA-wide shift from a hospital-based system to one providing access through primary care-based outpatient clinics, and budgetary compromises have probably played a role in individual instances. However, anecdotal responses from VA facilities suggest that a decreased demand for beds is the primary factor. New therapeutic modalities, including medications and psychosocial interventions, have resulted in more patients being successfully treated in an outpatient setting, reserving the inpatient setting for those patients who truly need acute episodes of care.

*Question 1d.* Where are the patients who used to get inpatient care in Pennsylvania now getting care? Can you demonstrate to me that the care they are getting now is better care?

Answer. There has been an increase in the total number of patients receiving care within Pennsylvania and VISN 4. Workload data for VISN 4 (ARC, 4/29/02) revealed a 3.7 percent increase in the total number of seriously mentally ill (SMI) patients treated in IFY 2001 when compared to IFY 1996. Within Pennsylvania, during this same time period, total SMI patients increased by 1.8 percent. These increases were most evident in the treatment of homelessness and PTSD. Inpatient and outpatient substance abuse treatment did show a decline of 19.2 percent (from 7,140 patients treated in FY 1996 to 5,767 in FY 2001). Within Pennsylvania, the decrease was 22 percent (from 6,490 to 5,064 patients treated). The Northeast Program Evaluation Center (NEPEC) located in West Haven, Connecticut, reports that, from FY 1996 to FY 2001, the number of unique veterans receiving mental health outpatient services in VISN 4 increased by 16.7 percent (from 31,365 to 36,590). Patients who were once treated on an inpatient psychiatric unit are now receiving services in outpatient settings. Many of these patients are now residing in VA-approved Community Residential Care (CRC) programs, one example of which is the 52-bed CRC program located on the grounds of VAMC Coatesville.

A number of VACO-approved and VISN planned enhancements will be implemented in FY 2003 to address deficiencies and enhance other services to the SMI veteran. In the area of substance abuse, opioid replacement services will be enhanced at Pittsburgh and Philadelphia VAMC's, and outpatient services will be expanded at five medical centers where the decline in substance abuse treatment services was most in evidence (Butler, Coatesville, Lebanon, Pittsburgh and Wilkes-Barre). PTSD treatment services were expanded in FY 2001 and FY 2002 at four medical centers (Erie, Philadelphia, Pittsburgh and Wilkes-Barre). In FY 2003, mental health services will be made available at all VISN 4 CBOCs with greater than 100 unique veterans served. There are also planned expansions of outpatient services to the seriously mentally ill veteran through enhancement of existing Mental Health Intensive Case Management (MHICM) services at Coatesville and Pittsburgh, and establishment of new MHICM teams at Clarksburg, Lebanon, Philadelphia and Wilkes-Barre VAMC's. NEPEC has documented that the incorporation of MHICM teams has produced significantly positive outcomes as related to the care and treatment of the SMI patient. This outpatient model, in conjunction with adequate supportive housing, has been proven to have greater outcome potential than a traditional inpatient psychiatric unit alone. VISN 4 is actively following this model of care through current and planned initiatives as noted.

*Question 2.* In Pennsylvania, the Coatesville VA Medical Center provides care to a significant number of geriatric patients who suffer with mental illness. In particular, the Coatesville VA operates an extensive Alzheimer's care program. Do you believe that some diagnoses—such as those treated in Coatesville's Alzheimer's pro-

gram—still require inpatient services? Are there not some veterans—those with Alzheimer's or other diagnoses—who must be treated in an inpatient setting?

Answer. In general, patients who have Alzheimer's dementia, a slowly progressive disorder, go through a series of phases that can last from months to years. A comprehensive system of dementia care includes a full continuum of services, including in-home, community-based, and institutional-based acute and extended care services, as well as support for family caregivers. Depending on the veteran's needs, VA services may include home-based primary care, homemaker/home health aide, respite, adult day health care, outpatient clinic, inpatient hospital, or nursing home care.

Care needs at a given stage, as well as over the course of the disorder, are highly individualized and influenced by a variety of factors including the presence of comorbid illnesses, presence of family or other caregivers, and the psychological, emotional, and social resources of both the person with dementia and his or her caregivers. With appropriate training and supportive services, some families desire and are able to care for the veteran with dementia at home virtually throughout the course of the disorder. For example, with training in behavior management and environmental safety issues, families may be able to manage difficult behaviors (e.g., wandering, aggressiveness, resistance to care) at home. With training and in-home services, families may be able to provide palliative care for persons with advanced dementia who prefer to die at home. In some cases, individuals with dementia may require short-term inpatient hospitalizations in order to stabilize behavior or manage co-morbid illnesses, with eventual return to the home setting. In other cases, families may be unable or unavailable to continue care at home at some point in the course of the disorder, and a longer-term institutional inpatient setting may be needed.

VA continues to seek ways to improve systems of care for veterans with dementia. Two major activities in this area include the Chronic Care Networks for Alzheimer's Disease (CCN/AD) initiative, co-sponsored by the National Chronic Care Consortium and the Alzheimer's Association; and the VA Advances in Home-Based Primary Care for End of Life in Advancing Dementia (AHEAD) rapid-cycle quality improvement project.

The bottom line is that there is no "one size fits all" approach, and more can be done in the home and community with appropriate training and support if that is what the patient and or their family wants. Inpatient settings are one important part of the full continuum of dementia care, but not all patients or families will want or need that level of care.

*Question 3a.* The Veterans' Health Care Eligibility Reform Act of 1996, Public Law 104-262, requires that VA maintain, at 1996 levels, its "capacity" to provide care to veterans in need of specialized services such as mental health services. I am advised that, since 1996, VA has reduced its average daily census of mental health inpatients from 12,500 to 3,800. Does VA believe that it is in compliance with the requirements of the Public Law 104-262? Is VA maintaining its "capacity" to treat mentally ill veterans? Please explain.

Answer. During the years immediately following 1996, VA lost some of its capacity to treat veterans with serious mental illness but we have worked hard in subsequent years to restore that capability. Data collection and analysis have been completed for the 2001 "Capacity Report," and the data indicate that for 2001, VHA has returned to its 1996 level of capacity to treat veterans with serious mental illnesses. In the area of substance abuse treatment however, we have not maintained this capability, and we are working to correct this deficiency.

*Question 3b.* In your view, does this statutory mandate compel VA to maintain a historical number of inpatient treatment beds? Or does it require that VA maintain the capability to provide treatment to historical numbers of patients—at whatever level of care is affordable or appropriate?

Answer. Public Law 104-262 did not define what was meant by the maintenance of capacity. Determining a definition was left to VA, and VA determined that capacity to treat veterans should be measured by the number of veterans treated each year in each of the special disability populations, and by the amount of money spent for that treatment. With the passage of Public Law 107-135, the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001, the requirements for measuring capacity have become more focused and specific. However, with the exception of measuring capacity for substance abuse disorders, the statute does not require VA to maintain a certain number of inpatient beds, and we believe this is appropriate. The empirical literature supports treating those with serious mental illnesses in the least restrictive environment with the full spectrum of community-oriented psychosocial rehabilitation treatments, including psychotropic medications. This is designed to assist those with serious mental illness to achieve the maximum

functional recovery and attain the highest level of functioning possible. VA's outpatient and residential psychosocial rehabilitation programs are designed to do this; treatment in an inpatient setting is used sparingly and only when needed.

*Question 4a.* During routine oversight visits, the Committee's staff has been told by VA clinicians that outpatient-based treatment for psychiatric care requires much greater VA "community coordination" to assure success. Is this so? If so, please explain for the record the sort of "community coordination" VA must undertake to achieve greater success.

*Answer.* Community coordination can mean working cooperatively with community agencies, families, and caregivers for planning and developing new programs as well as coordinating treatment and rehabilitation plans for individual veterans living in the community. Both are needed.

One of the best examples of coordinating services with the community involves VA's Community Homelessness Assessment Local Education and Networking Groups (CHALENG) for Veterans. As required by law, all VA medical centers and Regional Offices meet with representatives from other Federal Agencies, state and local governments, and non-profit organizations to assess the unmet needs of homeless veterans and develop action plans to meet those needs. For the last two years, 100 percent of VA medical centers have coordinated local CHALENG meetings. The FY 2001 CHALENG Report indicated that, across the nation, over 3,300 people participated in the CHALENG process. Approximately 16 percent of the participants were VA staff and 84 percent were participants from the community, including homeless veterans. The CHALENG process allows for a coordinated approach to determining the best methods for delivering those services.

In addition, VA's support of community-based residential programs through funding under the Grant and Per Diem Program fosters coordination and collaboration between VA and the community. An important aspect of this collaboration involves VA clinicians who conduct outreach to homeless veterans and provide case management services for veterans in community residential programs. Their constant presence in the community encourages coordination of care.

Community coordination for individual patients is best seen in VHA's mental health intensive case management (MHICM) program, in which individual counselors coordinate with family and community agencies to provide intensive day-by-day assistance in community living to recently discharged veterans with a severe and persistent mental illness.

Care coordination by mental health nurses and social workers for elderly veterans discharged from medical wards with co-morbid depression and anxiety was recently evaluated in a nine-site, six-year demonstration project called UPBEAT (Unified Psychogeriatric Biopsychosocial Evaluation and Treatment). One of the major roles of the care coordinators was to work with the veterans and their families in coordinating appointments with VA and community agencies as well as transportation to and from the appointments. The coordination and resource linkage services provided by the UPBEAT team varied broadly, ranging from provision of home-care services to procurement of legal and financial counseling. Care focused on optimizing outpatient interventions such as referral to community resources, outpatient clinic visits, focused group therapy, and home visits by UPBEAT staff.

*Question 4b.* What community-based resources or services does VA need to tap to assure success in an outpatient-based care setting? Please give me examples.

*Answer.* Community partnerships can enhance the services that VA provides to veterans receiving mental health services. VA staff regularly make referrals to community agencies for veterans in need of transitional housing, permanent housing, transportation, legal services, food stamps, and employment. We work with other federal agencies to ensure that veterans who qualify can access services and benefits from the Social Security Administration, Department of Housing and Urban Development, Department of Labor, Department of Transportation and the Department of Health and Human Services. VA was a voluntary participant in the President's New Freedom Initiative, partnering with other federal agencies to identify and remove barriers to community living for persons with disabilities. The VA New Freedom Initiative Report highlighted the services and programs for disabled veterans that have knocked down barriers to living and prospering in the community.

The VHA Community Residential Care program provides placements in VA-approved residential care homes for veterans in need of a structured living environment. Although VA does not pay for these services, VA social workers negotiate reasonable rates with residential care home operators. Veterans living in residential care homes receive lodging and meals in a safe, supervised environment. They are also provided with social and recreational activities and assistance with managing their medications. VA social workers visit veterans in the homes and conduct joint inspections of the facilities with VA life safety engineers. Before the Community

Residential Care Program was established, many of these veterans would have been placed in nursing homes or would have remained in long-term psychiatric hospitals. The biggest limitation to fully utilizing community residential care homes is that veterans need to have sufficient income to offset the costs. VA currently has no legislative authority to pay for community residential care, even though it is less costly than inpatient admissions or community nursing homes and provides a better quality of life for veterans.

Among the community based resources or services essential to maintain patients discharged from hospital and outpatient VA mental health care programs, are the partnerships that can be developed with community businesses through VHA's Compensated Work Therapy (CWT) Program. These partnerships represent a part of the continuum of care to assist veterans in the transition to independent and productive lives in their local communities. They should be expanded and made available to under-served veterans among the special disability groups, including substance abuse, serious mental illness, PTSD, and homeless veterans. Women veterans could also benefit greatly from this service and should be included.

CWT is authorized by 38 U.S.C. § 1718 to provide a supportive, stable, structured program utilizing work-based rehabilitation. Veterans in CWT are placed in work opportunities on a transitional basis with local employers or in a variety of federal agencies, including VA, to strengthen vocational identity and regain work skills. By working, veterans establish a source of income, structured use of time, and improved self-esteem.

In FY 2001, there were over 105 CWT programs that treated nearly 13,700 veterans. These veterans earned more than \$33 million, and 41 percent of those completing the program were placed in competitive employment with another four percent placed in training. An additional \$10 million dollars was received from participating companies and government agencies and used for program operating expenses, making this an extremely cost effective program for VA.

There is an innovative partnership with State chapters of the National Alliance for the Mentally Ill. There are nine State pilot projects working with VA and the local Alliance for the Mentally Ill to bring the Family-To-Family program to the VA veterans' families. This is a structured 12-week self-help course facilitated by persons trained in the Family-to-Family course who are usually family members themselves. This is directed at families of veterans with serious mental illness. It provides information about the illness, coping strategies and mutual support.

The Vietnam Veterans of America have offered a twelve-step recovery program called "Coping with the Aftermath of Vietnam" to veterans who suffer from PTSD. In some areas the local VHA Vet Center coordinates the referral.

The National Depressive and Manic-Depressive Association has been working with VHA Mental Health programs to provide information on the support groups that they sponsor. This is a program where clinicians in the VA refer veterans suffering from depression to one of the local support groups.

In the Northeast, the Bedford VA Medical Center and the Boston VA Outpatient Clinic have hosted a mental health peer support project that trains veterans with mental illness. Many people from the Peer Educators Project self help groups have gone on to be public educators. They also teach staff in our mental health programs about new ways of interacting with veterans who have mental illness.

The National Mental Health Association has several innovative models of care for people with schizophrenia and their families. The Partners in CARE (Community Access to Recovery and Empowerment) has several model programs that can be replicated. The programs represent a continuum of high-quality services, from low-intensity consumer self-help and support programs, to a fully integrated model of community-based service delivery that includes medication, social support services, employment, and rehabilitation.

For veterans with substance abuse problems, VA has contracted for years with community-based halfway houses to provide aftercare from more intensive, hospital-based rehabilitation programs. In a number of moderate-size cities VA facilities have referred veteran patients to local opioid substitution programs where there are insufficient numbers of heroin users to create a VA program. For decades, VA also has used Alcoholics Anonymous, Narcotics Anonymous, and other self-help organizations as major supports for veterans with addiction problems.

In North Carolina, which is fortunate to have a well-developed state-run community mental health program throughout the rural areas, many of our veterans who use VA for needed hospital care have also been able to receive outpatient care from local community programs. In Montana, VA has contracted for assertive community treatment (MHICM in VA) with a state funded non-profit organization.

*Question 4c.* Is such "coordination" not necessary when formerly-hospitalized patients are released to the community? Is "community coordination" more important

to patients treated primarily in an outpatient setting than it is to patients treated in an inpatient setting?

Answer. Depending upon the availability of mental health resources in specific communities, coordination with local agencies, organizations, and families is very helpful for both veterans discharged from inpatient settings and veterans treated on an outpatient basis. Coordination of VA and non-VA services is the key element in the rehabilitation of individual veterans discharged from a VA psychiatric inpatient setting. However, since most of our patients are served through a continuum of care, including both hospital and outpatient settings, community coordination, as part of the veteran's comprehensive treatment plan, cannot really be separated into inpatient or outpatient components.

*Question 4d.* Has VA central office devoted any resources, or developed any guidance for field clinicians, to increase local "coordination" by VA provider and local community service providers? Please explain.

Answer. VA's Office of Social Work Service oversees the practice of approximately 3,800 masters' prepared social workers in VHA facilities across the country. One of the primary functions of VHA social workers is to develop and maintain community linkages and to serve as the liaison between the VHA medical center and providers and staff in community agencies and organizations. Social workers serve as case managers for veteran patients, assuring coordination and continuity of care across all treatment settings and in the home and community. They develop and foster strong, regular communication with family members. Social workers make home visits and assess the family, social and community systems available to their veteran patients. They also keep current on the programs and services available from community agencies and organizations and help veterans and families access these services. Social workers coordinate VA community nursing home, community residential care, respite care, adult day health care, and homemaker and home health aide programs. These coordination functions include matching the needs of veterans with the various programs, making referrals, inspecting the homes and programs, providing case management services to veterans served in these programs, and keeping each patient's interdisciplinary treatment team informed about the patient's progress and the services he or she is receiving in the community.

VHA social workers assure the coordination of home and community services and the case management of veterans receiving outpatient Mental Health treatment. Such coordination and case management has led to reduced hospital admissions and reduced emergency visits, and better quality of life for veterans.

Social Work Service in VA Central Office has published VHA Social Work Practice Guidelines on case management, psychosocial assessment, psychosocial treatment, and discharge planning coordination. All of these guidelines include expectations for active community involvement and coordination. Social Work Service has also published standardized position descriptions, scope of practice statements, and a VHA directive outlining community coordination functions for social workers and social work leaders.

The VHA Office of Geriatrics and Extended Care has issued handbooks and directives providing guidance on community coordination of services provided in community nursing homes and community residential care homes, as well as adult day health care, respite care, homemaker/home health aide, hospice and palliative care services provided in veterans' homes and in the community.

The VA Employee Education Service (EES) has produced four videotapes on case management, highlighting "best practices" in VA medical centers. They have also developed a case manager position description, a tool kit of resources for VHA case managers and an assessment tool for case managers to use with veteran patients. Copies of the videotapes and other materials were provided to each VHA medical center. All of the case management products developed by EES stress the importance of the continuum of care in the community and homes of veterans and the key function of VHA case managers in coordinating care with community providers.

VHA's Mental Health Program Guidelines provide descriptions and definitions of various levels of case (or care) management including "linkage with other providers and services as needed and coordination of care among them."

*Question 5a.* I am told that many mental illnesses—even very serious mental illnesses such as schizophrenia—can be successfully treated on an outpatient basis with medications. Is this correct? If so, how do you assure that patients take their "meds" if they are not in the hospital?

Answer. That is correct. The great part of our treatment of veterans with a serious mental illness has been on an outpatient basis for many decades. Congress authorized VA Mental Hygiene Clinics, Day Treatment Centers, and Day Hospitals in the early 1950s. Before 1970, VHA had several dozen hospitals that provided long-term psychiatric hospital care and approximately 140 hospitals with psychiatric

beds that provided short-term hospital care and outpatient care. With better medications, psychosocial treatments, and expansion of outpatient care nationally, the shift away from long-term hospital-based care to community care accelerated both within and outside of VHA. Hospitals are now seen primarily as a necessary place to stabilize patients, but the primary treatment setting is now in the community. In FY 2000 (the latest year for which data are available), VHA provided care to 192,982 veterans with a psychosis; over 102,000 of these had a diagnosis of schizophrenia and nearly 62,000 had a diagnosis of bipolar disorder. Of these patients, 20 percent received some inpatient psychiatric care, averaging 20.6 days per year, but only 2.4 percent (4,630 patients) stayed over 150 days. Ten percent of the overall number received either some residential rehabilitation domiciliary, vocational or nursing home care. In FY 2000, 98.8 percent of veterans with a psychosis used outpatient care.

The issue of medication “compliance” has been researched since antipsychotic medications were developed in the mid 1950’s, and hundreds of articles have been published showing the efficacy of these new “anti psychotic” medications. In fact these medications have made it possible for many patients who had previously been hospitalized for years to go back home or find a supportive living arrangement in the community. In VA, outpatient follow-up has been a key to maintaining compliance with taking medications. Generally, outpatients take their medications when they trust their physician, have family support, are not substance abusers, are seen in the clinic regularly, and see some benefit in doing so in spite of the inconvenience and often some unpleasant side effects. Influence of families is very important. For those patients who respond favorably to medications, the incentive to avoid a recurrence of their psychotic state is compelling. Outpatients who are unable to comply are seen at appropriate intervals in the clinic, where they may be given an injection by a nurse that will last for a week or more. Some states have experimented with “outpatient commitment” to improve compliance. Even in the hospital, patients have been known to “cheek” their medications and fool the nurses for days at a time. Blood tests have been used to check for medication levels but are generally not found to be necessary.

*Question 5b.* When seriously mentally ill patients do not take their “meds,” what happens? Is it necessary to hospitalize them? After they are stabilized and back on their meds, are they then released? If so, is the cycle then repeated—perhaps endlessly?

*Answer.* Re-hospitalization is often necessary when patients do not take their medications, unless they are followed closely as outpatients by clinicians and family members where the recurrence of symptoms gives an early warning. In earlier studies, the monthly re-hospitalization rate of patients who stopped taking their medications was generally lower than the “controls” (who were given placebo medications), but higher than those who did continue to take their medications. Currently the relapse rates for patients with schizophrenia are estimated to be 3.5 percent per month for patients who take antipsychotic medications regularly over the long term and 11.0 percent for patients who have discontinued their medications. Relapse due to the lack of efficacy of the anti-psychotic medications is estimated to account for 60 percent of the considerable costs of re-hospitalization. Relapse due to non-compliance accounts for the remaining 40 percent of the costs, particularly in the second year. The readmission cycle referred to is mitigated by close outpatient follow-up where medication doses can be changed or new or additional medications added to achieve better outcomes. The addition of assertive community treatment (e.g., VA’s MHICM program) has very effectively broken the readmission cycle even for veterans with the most serious mental illnesses.

*Question 6a.* VA has unique resources at its disposal that could assist States and other local providers in their provision of mental health services to veterans and others. For example, the Butler VA Medical Center is now attempting to execute an enhanced use lease with the local county to provide space on hospital grounds for the county to use for care of local citizens with mental illness. Do you favor this sort of cooperative effort between VA and its “host” localities?

*Answer.* Enhanced-Use Leases (EUL) provide a unique mechanism to meet the Department’s mission requirements, and VA strongly encourages their use. The proposed enhanced-use business plan for the Butler VA Medical Center, which would establish a residential intermediate care mental health facility for the community, would be the Department’s first use of an EUL for this purpose.

*Question 6b.* In this particular case, the process of VA headquarters approval of the enhanced use lease is caught up in VA bureaucracy. If it is not approved soon, many citizens in Western PA could suffer the consequences. Please report on the status of VA central office review of the enhanced use lease application submitted by the Butler VA Medical Center.

Answer. The proposal is for the development of a Butler County Human Services Mental Health Intermediate Care facility on underused land at the VA Medical Center in Butler, PA. The conceptual business plan was submitted to the Veterans Health Administration (VHA) on April 15, 2002.

During June and July 2002, additional information was requested by and submitted to the VHA Office of Facilities Management, which subsequently concurred with the proposal, and forwarded it for further Department-level review.

County officials who are responsible for development of the proposed intermediate care psychiatric facility have expressed concern about the possibility of losing state funding. Assuming Department-level approval is forthcoming, VA staff will work with local officials to resolve any potential scheduling issues.

*Question 6c.* Please outline the steps for VA central office review of the enhanced use lease applications. What is the purpose of each step? Is each step necessary? How long does it typically for VA central office to process its review of an enhanced use lease application?

Answer. VA's EUL authority is a capital asset management program that is unique to the Department. The program provides a proven method of leveraging VA's diverse real estate portfolio with private and other public sector markets. The typical milestones for enhanced-use lease authority include:

- Submission of the Conceptual Business Plan, with endorsement by the Network Director, to the appropriate Administration;
- Internal Administration Concept Plan Scoring for prioritization—14 days;
- Administration and OAEIVI approval of the Concept Plan—approximately 30 days after submission;
- Public Hearing—approximately 30–45 days after approval;
- Congressional Notification of the Department's Intent to Designate the site for an EUL (minimum 90 calendar days for congressional review before VA can execute the enhanced-use lease)—submitted approximately 30 days after the public hearing;
- Solicitation and selection of Developer/Lessee, if required—90 days;
- Developer preparation and finalization of Development Plan—60 days;
- VA approval of Development Plan—45 days after submission;
- Strategic Management Council and OMB Clearance, if required;
- Congressional Notification of the Department's Notice of Designation and Intent to Execute the EUL (30 calendar days required by statute)—30 days after all clearances;
- Execution of Enhanced-Use lease—30 days after submission of Notice of Intent to Execute;

The milestones and timeline presented above allow VA to present EULs in 12–18 months. It should be emphasized that we are reviewing the EUL process to determine how we might improve and shorten this timeline.

*Question 7.* Testimony presented by Colleen Evans, RN, states that VA has closed too many inpatient substance abuse treatment beds in Pittsburgh. Is this contention accurate, in your estimation? What is VA's policy on providing inpatient substance abuse treatment? Is it possible that VA has gone too far in closing inpatient substance abuse treatment beds in an effort to save the system money?

Answer. The VA Pittsburgh Healthcare System (VAPHS) transitioned the substance abuse program from an inpatient unit to an outpatient continuum of care in June 1998. This change was in response to a low census on that unit, and this change paralleled the standard of treatment provided in the private sector.

Within the current continuum of care, there are 15 beds (with the availability of 5 additional beds) in the Domiciliary for patients in the entry level for substance abuse treatment. If we compare program utilization for FY 1998, which was the last year of the inpatient program, to the current outpatient model with the availability of Dom beds, the program meets patient needs to a greater extent.

	FY 1998	FY 2002 (YTD)
Average Daily Census .....	13.2 .....	16.2
Occupancy Rate .....	43.6% .....	107% (for 15 beds)
Average Length of Stay .....	10.8 days .....	13.9 days

*Question 8.* Ms. Evans also testified that changes in policy at the medical center level have made it practically impossible for a patient to obtain substance abuse treatment while he or she is an acute psychiatric inpatient. She suggests that because patients are not permitted to walk to the outpatient treatment sessions on their own—and there is too little staff to escort them—these patients are essentially going without treatment. Are Ms. Evans' contentions valid? Should more staff be hired? Should patients in acute psychiatric care be allowed to walk unescorted to

the outpatient treatment sessions? If not, should hospital management see to it that such patients either get appropriate escorts? Or should it assure that treatment services are brought to the inpatient setting?

Answer. On any given week, there are 2 patients who are referred to the substance abuse program during their inpatient stay. To begin entry-level work with these patients prior to discharge, the substance abuse program provides a motivational group three times a week on the inpatient unit. This is an approach which is patient centered, bringing the treatment program to the patient in a safe environment. The staff comes to the patients; therefore, escorting is not necessary.

*Question 9a.* A report issued by VA's Advisory Committee on the Readjustment of Veterans expresses concerns about the reduction of inpatient PTSD programs. In 1993, there were approximately 20 inpatient programs providing care to veterans suffering from PTSD. Today, there are seven. What has occurred over the last 9 years that has allowed VA to significantly reduce its capacity for inpatient treatment of veterans suffering from PTSD?

Answer. As with other health care generally, including mental health care, treatment of PTSD is increasingly being provided on an outpatient basis. Although providing care on an outpatient basis reduces costs, there are other important reasons why health care continues to shift to the outpatient settings. Health care providers and patients themselves recognize that health care should be provided in the least restrictive environment possible. Inpatient care must be available when needed but should be reserved for those situations where outpatient care alternatives are either unavailable or clinically inappropriate. Further, there is no evidence to suggest that providing care in an outpatient setting, where clinically appropriate, in any way compromises the quality of care or adversely affects clinical outcomes. VA has developed a continuum of outpatient and residential psychosocial rehabilitation programs designed to help veterans achieve the highest level of functioning possible. Although acute inpatient capacity has diminished in VHA, specialized residential and outpatient treatment programs have grown.

*Question 9b.* Is there any data to suggest that caring for veterans suffering from PTSD in an outpatient setting is more appropriate than—or yields better outcomes than—inpatient care?

Answer. There are no data to suggest that outpatient care for veterans suffering from PTSD is more appropriate or yields better outcomes than inpatient care. On the other hand, there are also no data to suggest that outpatient outcomes are inferior to inpatient outcomes. It should be recognized that most PTSD treatment has always been delivered on an outpatient basis through specialized outpatient clinics and Vet Centers. Especially with the development of Post Traumatic Stress Disorder Clinical Teams, clinical staff have learned a great deal about treating PTSD in the outpatient setting. Data on the clinical outcomes of VA's specialized intensive PTSD programs show that these programs have maintained their effectiveness in reducing symptoms, substance abuse, and violent behavior. In addition, non-experimental outcome studies of specialized VA PTSD inpatient and outpatient programs show that they have similar patient outcomes during the year following program entry.

*Question 9c.* Do you believe that VA is capable of providing inpatient PTSD services to all veterans in need of such care?

Answer. Although specialized acute inpatient PTSD capacity has declined in recent years, PTSD patients have access to acute inpatient care services on general mental health units for short-term stabilization, crisis intervention, and for other medical reasons. Most networks have residential rehabilitation capacity to treat PTSD, and all networks have some capacity to provide specialized treatment services on either an inpatient or outpatient basis.

Public Law 106-117, the "Veterans Millennium Health Care and Benefits Act", provided an opportunity to expand programming for PTSD in order to fill gaps in services. In July 2000, 21 Networks, encompassing 69 facilities, submitted proposals to develop additional specialized treatment for PTSD. The total amount of funds requested was \$13,975,686. Eighteen proposals were ultimately funded in the amount of approximately \$5.5 million, leaving a documented unmet need of almost \$8.5 million. This may be a significant underestimate of the overall additional need, however, for a number of reasons. Proposals were only funded to support recurring funding needs. Additional one-year startup costs are not included in the \$5.5 million. More significantly, not all program needs within each network were submitted for national review. Many networks conducted an internal prioritization exercise and only submitted their highest priority needs. Had more money been available, we believe that the total number of submissions and the cost per submission would have been considerably higher.

*Question 10a.* On July 12, 2002, Secretary Principi sent Chairman Rockefeller and me a letter detailing the waiting times veterans face at VA Medical Centers around

the country. In my home state of Pennsylvania, the data showed an alarming number of veterans—over 26,000—are waiting for care. What are the waiting times currently facing veterans for outpatient mental health services?

Answer. Attached is an excel spreadsheet with waiting time data for mental health (MH) clinics in the state of Pennsylvania.

## July Wait Times Mental Health Clinic Stops

State	WSN	Sta5a	Name	PRIMARY DSS STOP	Type of CBQC/Division	Total Apts Scheduled	Number of Apts That are Next Available	Number of New Patient Apts	Average Next Available Wait Time	Average New Pa- tient Wait Time (recoded as next as next available)	Percent of ALL Apts Scheduled in 30 days
PA	4	646A5	Pittsburgh HCS-Highl	ACT DUTY SEX TRAUMA	VA PROVIDED	50	0	0	0.0	7.9	100.0%
PA	4	562	Erie	DAY TRMT-GRP	VA PROVIDED	210	35	0	0.0	0.0	100.0%
PA	4	646A5	Pittsburgh HCS-Highl	DAY TRMT-GRP	VA PROVIDED	8	0	0	0.0	19.0	100.0%
PA	4	503	James E. Van Zandt	DAY TRMT-IND	VA PROVIDED	69	0	0	0.0	66.2	100.0%
PA	4	642	Philadelphia	HCHV/HMI	VA PROVIDED	86	26	3	0.2	0.4	100.0%
PA	4	693B4	Allentown	HCHV/HMI	VA PROVIDED	63	0	0	0.0	7.0	100.0%
PA	4	693GB	Williamsport	MEN HILTH RESID CARE	VA PROVIDED	1	0	0	0.0	10.0	100.0%
PA	4	646A5	Pittsburgh HCS-Highl	MEN HILT INT (MHICM)	VA PROVIDED	1	0	0	0.0	0.0	100.0%
PA	4	503	James E. Van Zandt	MENTAL HEALTH-IND	VA PROVIDED	285	56	22	38.9	35.4	78.6%
PA	4	529	Butler	MENTAL HEALTH-IND	VA PROVIDED	1021	15	9	19.9	36.1	99.4%
PA	4	542	Coatesville	MENTAL HEALTH-IND	VA PROVIDED	148	1	0	7.0	16.6	98.6%
PA	4	562	Erie	MENTAL HEALTH-IND	VA PROVIDED	831	0	0	0.0	29.1	100.0%
PA	4	642	Philadelphia	MENTAL HEALTH-IND	VA PROVIDED	841	203	12	18.9	11.7	95.8%
PA	4	693	Wilkes Barre	MENTAL HEALTH-IND	VA PROVIDED	189	13	11	24.1	41.0	73.8%
PA	4	542GA	Media	MENTAL HEALTH-IND	VA PROVIDED	29	0	0	0.0	0.0	100.0%
PA	4	542GC	Reading/Berks	MENTAL HEALTH-IND	VA PROVIDED	48	0	0	0.0	14.6	97.9%
PA	4	542GE	Spring City	MENTAL HEALTH-IND	VA PROVIDED	79	0	0	0.0	1.8	100.0%
PA	4	693B4	Allentown	MENTAL HEALTH-IND	VA PROVIDED	481	157	41	72.3	57.8	65.9%
PA	4	693GA	Sayre	MENTAL HEALTH-IND	VA PROVIDED	61	0	0	0.0	89.7	58.0%
PA	4	693GB	Williamsport	MENTAL HEALTH-IND	VA PROVIDED	144	5	4	3.6	43.7	97.9%
PA	4	503	James E. Van Zandt	MENTAL HYG-GRP	VA PROVIDED	125	0	0	0.0	47.2	100.0%
PA	4	529	Butler	MENTAL HYG-GRP	VA PROVIDED	193	1	0	92.0	5.5	92.0%
PA	4	542	Coatesville	MENTAL HYG-GRP	VA PROVIDED	10	0	0	0.0	0.0	100.0%
PA	4	562	Erie	MENTAL HYG-GRP	VA PROVIDED	54	0	0	0.0	0.0	100.0%
PA	4	642	Philadelphia	MH INV BIOMED CARE-IND	VA PROVIDED	31	1	0	20.0	0	100.0%
PA	4	646	Pittsburgh HCS-Univ	MH INV BIOMED CARE-IND	VA PROVIDED	109	35	23	20.1	19.4	91.6%
PA	4	595	Lebanon	MH PRIM CARE TEAM-GRP	VA PROVIDED	12	0	0	0.0	0.0	100.0%
PA	4	646A5	Pittsburgh HCS-Highl	MH PRIM CARE TEAM-GRP	VA PROVIDED	748	0	0	0.0	29.9	99.9%
PA	4	595	Lebanon	MH PRIM CARE TEAM-IND	VA PROVIDED	1260	26	11	10.1	35.9	89.7%
PA	4	642	Philadelphia	MH PRIM CARE TEAM-IND	VA PROVIDED	867	270	56	45.8	48.5	79.1%
PA	4	646	Pittsburgh HCS-Univ	MH PRIM CARE TEAM-IND	VA PROVIDED	180	6	4	45.3	17.6	95.4%
PA	4	693	Wilkes Barre	MH PRIM CARE TEAM-IND	VA PROVIDED	8711	5	4	14.7	63.5	92.2%

PA	4	595GA	Camp Hill Outpatient	MH PRIM CARE TEAM-IND	VA PROVIDED	482	6	0	8.8	26.7	98.3%
PA	4	646A4	Pittsburgh HCS-Aspir	MH PRIM CARE TEAM-IND	VA PROVIDED	2	0	0	0.0	5.0	100.0%
PA	4	646A5	Pittsburgh HCS-Highl	MH PRIM CARE TEAM-IND	VA PROVIDED	2720	116	27	21.4	25.8	98.3%
PA	4	693GC	Tooyhanna	MH PRIM CARE TEAM-IND	VA PROVIDED	14	1	1	114.0	137.0	85.7%
PA	4	562	Erie	MH RISK FAC RED EDU GRP	VA PROVIDED	88	0	0	0.0	23.0	95.7%
PA	4	542	Coatesville	MH TEAM CASE MGT	VA PROVIDED	14	0	0	0.0	26.7	100.0%
PA	4	595	Lebanon	MH VOCAT ASSIST	VA PROVIDED	269	13	1	0.9	2.5	99.6%
PA	4	642	Philadelphia	OPIOID SUBSTITUTION	VA PROVIDED	24632	0	0	0.0	0.2	99.9%
PA	4	646A5	Pittsburgh HCS-Highl	OPIOID SUBSTITUTION	VA PROVIDED	1531	0	0	0.0	3.0	100.0%
PA	4	542	Coatesville	PCT PTSD-GRP	VA PROVIDED	122	10	0	0.0	0.0	99.2%
PA	4	642	Philadelphia	PCT PTSD-GRP	VA PROVIDED	7	3	0	9.0	0.0	100.0%
PA	4	646A5	Pittsburgh HCS-Highl	PHONE GENERAL PSYCH	VA PROVIDED	164	2	0	7.5	21.3	100.0%
PA	4	642	Philadelphia	PSY/SOC REHAB-GRP	VA PROVIDED	10	0	0	0.0	0.0	100.0%
PA	4	693B4	Allentown	PSYCHIATRY CONS	VA PROVIDED	35	0	0	0.0	14.1	100.0%
PA	4	595	Lebanon	PSYCHIATRY-IND	VA PROVIDED	529	86	28	24.9	31.3	91.1%
PA	4	503	James E. Van Zandt	PSYCHIATRY-IND	VA PROVIDED	731	14	6	11.6	11.7	97.7%
PA	4	562	Erie	PSYCHIATRY-IND	VA PROVIDED	102	0	0	0.0	9.7	100.0%
PA	4	642	Philadelphia	PSYCHIATRY-IND	VA PROVIDED	2406	885	143	31.0	21.7	80.4%
PA	4	693	Wilkes Barre	PSYCHIATRY-IND	VA PROVIDED	194	1	0	49.0	63.8	86.8%
PA	4	542GA	Media	PSYCHIATRY-IND	VA PROVIDED	160	1	0	0.0	34.4	83.1%
PA	4	542GC	Reading/Berks	PSYCHIATRY-IND	VA PROVIDED	51	0	0	0.0	27.6	88.1%
PA	4	542GD	Lancaster	PSYCHIATRY-IND	VA PROVIDED	47	2	0	3.0	17.0	97.9%
PA	4	542GE	Spring City	PSYCHIATRY-IND	VA PROVIDED	134	2	0	23.5	39.5	98.5%
PA	4	542GG	Philadelphia	PSYCHIATRY-IND	VA PROVIDED	69	3	0	35.3	11.6	94.2%
PA	4	595	Lebanon	PSYCHOLOGICAL TESTING	VA PROVIDED	32	1	0	21.0	17.6	100%
PA	4	595GA	Camp Hill Outpatient	PSYCHOLOGICAL TESTING	VA PROVIDED	2	2	2	41.0	41.0	0.0%
PA	4	542	Coatesville	PSYCHOLOGY-GROUP	VA PROVIDED	178	0	0	0.0	48.7	98.1%
PA	4	693	Wilkes Barre	PSYCHOLOGY-GROUP	VA PROVIDED	332	0	0	0.0	32.6	100.0%
PA	4	693134	Allentown	PSYCHOLOGY-GROUP	VA PROVIDED	17	0	0	0.0	0.0	100.0%
PA	4	503	James E. Van Zandt	PSYCHOLOGY-IND	VA PROVIDED	245	47	17	31.3	23.2	73.3%
PA	4	542	Coatesville	PSYCHOLOGY-IND	VA PROVIDED	99	16	6	7.9	11.9	100.0%
PA	4	562	Erie	PSYCHOLOGY-IND	VA PROVIDED	26	25	21	23.8	25.7	84.6%
PA	4	595	Lebanon	PSYCHOLOGY-IND	VA PROVIDED	46	2	2	22.0	9.7	95.7%
PA	4	642	Philadelphia	PSYCHOLOGY-IND	VA PROVIDED	90	44	16	20.1	17.3	90.8%
PA	4	693	Wilkes Barre	PSYCHOLOGY-IND	VA PROVIDED	218	11	4	88.5	44.9	86.3%
PA	4	542GA	Media	PSYCHOLOGY-IND	VA PROVIDED	105	0	0	0.0	0.0	100.0%
PA	4	542GE	Spring City	PSYCHOLOGY-IND	VA PROVIDED	73	1	0	1.0	19.7	86.3%
PA	4	542GG	Philadelphia	PSYCHOLOGY-IND	VA PROVIDED	95	0	0	0.0	5.0	100.0%
PA	4	595GA	Camp Hill Outpatient	PSYCHOLOGY-IND	VA PROVIDED	11	11	10	40.4	40.1	9.1%

## July Wait Times Mental Health Clinic Stops—Continued

State	V/SN	Sta5a	Name	PRIMARY DSS STOP	Type of CBOC/Division	Total Apts Scheduled	Number of Apts That are Next Available	Number of New Patient Apts	Average Next Available Wait Time	Average New Pa- tient Wait Time (recoded as next available)	Percent of ALL Apts Scheduled in 30 days
PA	4	646A5	Pittsburgh HCS-Highl	PSYCHOLOGY-IND	VA PROVIDED	80	0	0	0.0	16.2	100.0%
PA	4	693B4	Allentown	PSYCHOLOGY-IND	VA PROVIDED	100	28	7	130.0	116.9	69.8%
PA	4	542	Coatesville	PTSD CL TEAM-PCT	VA PROVIDED	271	38	6	8.4	12.9	99.3%
PA	4	642	Philadelphia	PTSD CL TEAM-PCT	VA PROVIDED	908	361	26	26.1	12.5	90.6%
PA	4	542GA	Media	PTSD CL TEAM-PCT	VA PROVIDED	55	5	1	5.0	6.6	100.0%
PA	4	542GC	Reading/Berks	PTSD CL TEAM-PCT	VA PROVIDED	22	1	1	13.0	9.5	100.0%
PA	4	542GD	Lancaster	PTSD CL TEAM-PCT	VA PROVIDED	50	7	0	6.1	0.0	100.0%
PA	4	646A5	Pittsburgh HCS-Highl	PTSD CL TEAM-PCT	VA PROVIDED	280	14	4	24.9	30.6	98.1%
PA	4	503	James E. Van Zandt	PTSD GROUP	VA PROVIDED	111	0	0	0.0	0.0	100.0%
PA	4	562	Erie	PTSD GROUP	VA PROVIDED	38	0	0	0.0	0.0	100.0%
PA	4	595	Lebanon	PTSD GROUP	VA PROVIDED	66	1	0	6.0	0.0	100.0%
PA	4	562	Erie	PTSD-INDIVIDUAL	VA PROVIDED	93	0	0	0.0	10.7	100.0%
PA	4	693GB	Williamsport	PTSD-INDIVIDUAL	VA PROVIDED	8	3	3	2.7	2.7	100.0%
PA	4	562	Erie	SUBST ABUSE-GRP	VA PROVIDED	7	0	0	0.0	0.0	100.0%
PA	4	595	Lebanon	SUBST ABUSE-GRP	VA PROVIDED	7	6	6	4.3	4.6	100.0%
PA	4	642	Philadelphia	SUBST ABUSE-GRP	VA PROVIDED	130	12	2	1.5	14.0	100.0%
PA	4	646A5	Pittsburgh HCS-Highl	SUBST ABUSE-GRP	SUBST ABUSE-GRP VA PROVIDED	227	8	0	0.0	0.0	96.9%
PA	4	529	Butler	SUBST ABUSE-IND	VA PROVIDED	4	2	0	21.5	0.0	75.0%
PA	4	542	Coatesville	SUBST ABUSE-IND	VA PROVIDED	46	3	3	7.3	5.7	100.0%
PA	4	562	Erie	SUBST ABUSE-IND	VA PROVIDED	82	0	0	0.0	19.3	100.0%
PA	4	642	Philadelphia	SUBST ABUSE-IND	VA PROVIDED	936	162	72	7.4	9.8	99.9%
PA	4	542GE	Spring City	SUBST ABUSE-IND	VA PROVIDED	28	0	0	0.0	20.8	100.0%
PA	4	646A5	Pittsburgh HCS-Highl	Pittsburgh HCS-Highl	SUBST ABUSE-IND VA PROVIDED	146	0	0	0.0	7.4	100.0%
PA	4	646	Pittsburgh HCS-Univ	SUBST/PTSD TEAMS	VA PROVIDED	15	0	0	0.0	0.0	100.0%
PA	4	646A5	Pittsburgh HCS-Highl	SUBST/PTSD TEAMS	VA PROVIDED	287	0	0	0.0	19.8	100.0%

*Question 10b.* Are these waiting times so long that VA, in effect, is simply refusing care to seriously mentally ill veterans who need such services?

Answer. VA is not refusing care to any veteran with serious mental illness. All patients with urgent or emergency needs are seen immediately. For routine, non-urgent MH appointments, the average next available appointment ranges from 3.6 to 130 days. During the past year, we have monitored access to MH services in Community-Based Outpatient Clinics during the Network Directors' quarterly performance reviews. Discussions have emphasized the need to have MH services available either directly on site or by referral to the parent facility. VISN 4 also has had an initiative with Murray/Tantau Associates over the past year to decrease waiting times and MH clinics are included in this initiative. With time, we should see a decrease in waiting times for MH clinics.

*Question 10c.* How does VA "triage" its waiting list to assure that veterans in need of immediate care are moved to the "front of the line"?

Answer. Patients with urgent or emergency needs are seen immediately in VA emergency areas or are referred within the community for emergency care. Once seen in that setting, the patient can then be referred for continuing care. If a patient requiring routine, non-urgent care has been placed on a wait list, he or she will be removed from the wait list as openings occur on a first on, first off basis. If the patient's need subsequently becomes urgent or an emergency, he or she will be seen immediately.

*Question 11.* A report in the June 9, 2002 edition of the Hudson Valley (NY) Times Herald Record detailed cases of four mentally ill veterans who were allegedly given poor care at, or were prematurely discharged from, the Montrose VA Medical Center. One veteran allegedly murdered his girlfriend, another apparently overdosed on drugs, and two others killed themselves. Has VA investigated these cases? Please report on the care afforded to these patients.

Answer. VA has investigated these cases. The VISN 3 Network Director authorized his own investigation, and the Office of Inspector General is also reviewing the cases, and plans on issuing two separate reports, one in October and one in November.

[Redacted]:

[Redacted] was discharged from Montrose VAMC on February 21, 2001. Mental health staff had worked extensively preparing the veteran for community transition including visiting several different community homes. The patient elected the [redacted]. In addition to the housing plan, the veteran was accepted to the VA MHICM program. The MHICM case manager called to check on whether [redacted] was adapting to the new environment, and visited him on February 23, at which time the veteran reported he was adjusting. A root cause analysis was completed on 5/01/02. Recommendations have been implemented to improve the monitoring of high-risk discharges to the community. The current pending policy ensures that treatment providers participate in and are in agreement with the discharge plan. Staff on the chronic psychiatric unit has been educated on the level of care and function of the community residences and the role of intensive case managers.

[Redacted]:

[Redacted] completed the 45-day [Redacted] program. Prior to entering this program the veteran violated conditions of parole and was going to be sent to jail due to the determination of law enforcement officials. Montrose staff had agreed to screen [Redacted] for the PTSD program upon the completion of his jail sentence, although he had been treated for PTSD at Montrose on three previous occasions (1997, 1998, and 2000). It is the written policy of the program not to accept patients to this intense program while there are pending legal issues. Although the patient was anxious about imminent incarceration, [Redacted] denied any suicidal ideation and was discharged to his home while awaiting imprisonment. [Redacted], the police report indicated acute morphine intoxication, consistent with past substance abuse behavior. This occurred while the patient was at home in bed with his wife. The report further stated, "Due to the past history, this incident was not considered suspicious".

[Redacted]:

[Redacted] requested to be discharged from the [Redacted] program after being denied an increase in [Redacted], which he was receiving while detoxing from alcohol and heroin intoxication. Although staff encouraged him to stay, he was granted his request for discharge since there was no evidence of suicidal or homicidal ideation. Staff attempted to refer [Redacted] for shelter, which he refused. There is no entry in the patient's medical record indicating that the patient should not have been discharged, [redacted]. The Metropolitan Transit Authority police report stated that

the engineer operating the train that hit [Redacted] witnessed [Redacted] stumble to get out of the way of the train. This is consistent with the autopsy report indicating an elevated level of alcohol in his system. The autopsy report maintained that the death was of an accidental nature.

[Redacted]:

[Redacted] was last seen at the Montrose facility for mental health treatment in January 1997. At that time he had scheduled outpatient visits that he did not keep. He participated in volunteer work on the Montrose campus until 1999. All subsequent visits were for outpatient urology and optometry, the last one being in September 2001. [Redacted], there is no record of [Redacted] appearing in the Montrose emergency room and requesting inpatient treatment on the date mentioned. Furthermore, [Redacted], who was the victim and a nurse aid at the Montrose facility, filed an order of protection in December 1999 against [Redacted], indicating premeditated thoughts of violence, not violence due to an acute psychotic episode.

*Question 12.* Your prepared testimony notes that VA is providing a wide variety of medical treatment and other social services to mentally ill veterans in need of care. You go into great detail on the amount of money spent providing mental health care and purchasing prescription drugs. In short, you paint quite a positive picture of VA's mental health capabilities. Are there any shortcomings in VA's provision of mental health services to veterans in need of such care?

Answer. Although the VA health care system is effective in the provision of mental health services, no system is perfect. The following are areas in which we could make improvements.

**ACCESS TO SUBSTANCE ABUSE SERVICES.** In response to the requirement of section 116 of the Veterans Millennium Health Care and Benefits Act, Public Law 106-117, VHA received 101 requests for new or enhanced substance abuse programs. Thirty-one of these requests were funded. The remaining 70 projects indicate additional need for specialized substance abuse care. Twelve U.S. cities with documented serious heroin problems have no methadone maintenance clinic at the local VA medical facility, indicating a need for VA to develop such services.

**MENTAL HEALTH INTENSIVE CARE MANAGEMENT (MHICM) PROGRAMS.** In October 2000, we identified 9,538 MHICM "eligible" veterans. This figure is based on the number of veterans discharged from a psychiatric inpatient program with a serious mental illness diagnosis and either three admissions or 30 hospital days in FY 2000. As of March 31, 2002, we have 3,298 MHICM patients in our programs. Those figures suggest a need for 6,240 additional slots.

**PSYCHOSOCIAL REHABILITATIVE SERVICES.** A 77 percent sampling of patients with serious mental illness in FY 2000 revealed that 54 percent scored below 50 on the Global Assessment of Functioning (GAF), indicating significant functional impairment. This suggests that approximately 105,000 veterans might benefit from recovery-oriented psychosocial rehabilitative services. However, in FY 2002, only 14,000 received such services in our psychosocial programs. Only 30,000 of the 678,000 veterans served in VA mental health programs in FY 2000 received any form of work-based rehabilitation, in spite of the clear and substantial evidence of the effectiveness of integrating work into most forms of treatment. Unemployment among people with mental illness, and particularly psychosis, is very high. Access to compensated work therapy programs, which can improve a patient's chances to become more functional in their community, is limited. Residential rehabilitation programs, designed as alternatives to hospitalization, have also not been fully developed nationally. To ensure equal access to VA residential services, it is estimated that an additional 22 Psychosocial Residential Rehabilitation Treatment Programs (PRRTPs) are needed.

**ACCESS IN COMMUNITY-BASED OUTPATIENT CLINICS (CBOCs).** We recognize the need to improve access to mental health services in CBOCs, particularly in those located in remote communities that may lack non-VA mental health services. Data suggest that between 10-20 percent of patients seeking general medical care in VA have mental disorders that would benefit from treatment.

**Specialized PTSD Treatment.** In July 2000, in response to the requirement of section 116 Public Law 106-117, 21 Networks, encompassing 69 facilities, submitted proposals to develop additional specialized treatment for PTSD. Eighteen proposals were funded. This may represent an underestimate of the overall additional need. For a number of reasons, not all program needs within each network were submitted for review. Many networks conducted an internal prioritization exercise and only submitted their highest priority needs.

In summary we have identified a number of areas in which we could expand or enhance our mental health services. It is important to recognize that we are actively working to fill these gaps in services, for example, with Network-based plans for

MHICM, provisions of mental health services in CBOCs, and substance abuse care expansion. WE face these challenges because VA provides high-quality mental health services that address the needs of veterans that in many cases cannot be met in their communities.

*Question 13a.* Your prepared testimony states that VA's Central Office has received and approved plans from all Network Directors to comply with the requirements of the Homeless Veterans Comprehensive Assistance Act of 2001, Public Law 107-95, that each VA outpatient clinic provide mental health services to all veterans needing such services. How will you monitor implementation of this mandate?

Answer. Implementation is monitored quarterly during each Network Director's Performance Reviews with the Deputy Under Secretary for Health for Operations and Management.

*Question 13b.* When will this mandate be met?

Answer. We anticipate that we will fully meet the mandate by the end of FY 2002.

Chairman ROCKEFELLER. Dr. Losonczy?

**STATEMENT OF MIKLOS LOSONCZY, M.D., CO-CHAIRMAN, COMMITTEE ON CARE OF VETERANS WITH SERIOUS MENTAL ILLNESS, ASSISTANT CHIEF OF STAFF FOR MENTAL HEALTH AND BEHAVIORAL SCIENCES, NEW JERSEY HEALTH CARE SYSTEM, AND ASSOCIATE PROFESSOR, DEPARTMENT OF PSYCHIATRY, ROBERT WOOD JOHNSON SCHOOL OF MEDICINE**

Dr. LOSONCZY. Thank you, Mr. Chairman and members of the committee. As the Co-Chair of the Committee on Care of Veterans with Serious Mental Illness, we are very appreciative of the opportunity to share our views about possible directions for mental health care in the VA.

As you have heard from Dr. Roswell, the VA does serve over 700,000 veterans annually in specialized mental health programs with a wide array of services. In the view of the SCMI committee, the VA has the potential for being clearly the benchmark in quality for mental health care in the United States. Despite these significant strengths, in the view of the committee, there are still areas for substantial gains.

The special focus of the SCMI committee is on the veteran who is disabled due to serious mental illness, a population which needs and relies on the Department for treatment and rehabilitation, and is a group central to the VA mission. The committee has monitored, from a variety of sources, access to specialized mental health services throughout the department, and has been struck by the degree of variability in these services across the various networks.

Over time, these variations have widened, leaving the committee to conclude that there is a need for national standards which are evidence- and population-based for the provision of mental health services. By performing a national mental health needs assessment, it would be possible to identify gaps in service and develop a national strategic plan to provide such services. Fully implemented, this should materially diminish the high variability of mental health services across the country and lead to better outcomes for this critical population of veterans, many carrying the emotional wounds of war for their lifetimes.

This recommendation, made in both the Fifth and Sixth Annual Reports of the SCMI Committee, is a natural outcome of concern by the committee that the VA has not systematically planned for large-scale deinstitutionalization of veterans with serious mental

illness over the past 6 years. The SCMI committee from its inception has strongly supported the development of an array of community support programs to enable discharged veterans to function well in the community. We thought living in the hospital was the wrong place for these veterans and they needed to be in the community, but with the right supports.

Logically, these programs should be in place before large numbers of veterans are discharged. Such programs should include intensive case management, supported housing, a spectrum of work restoration efforts, easy access to mental health services in the community, family support, and help with socialization. Together with appropriate medication management, these programs are key to foster recovery for veterans with serious mental illness.

The VA in 1995 was funded by mechanisms that reinforced the development of inpatient and not outpatient programs. The shift to the capitation funding mechanism in 1996 guaranteed pressure on managers to decrease inpatient costs without clear incentives to shift these savings to community support development efforts. From the analysis detailed in our written testimony, it appears that less than 20 percent of the savings from closing inpatient mental health beds were reinvested in new outpatient services, less than the increase in outpatient mental health demand alone.

The lack of even development of community support programs was noted in the committee's review of the department's capacity report. The committee and the department agreed in 1997 to define capacity for the SMI population as both the number of veterans served and dollars expended in their care as a measure of intensity of services, but avoiding beds or FTE as counterproductive measures. The committee discussed that appropriate inflationary adjustments would be needed over time to make this definition meaningful, but the department has inconsistently included inflation in its own reports.

Without an inflationary adjustment, the department has only found a capacity problem in maintaining its substance abuse services. Using inflation-adjusted dollars, the SMI committee in its 2000 report saw a total shortfall for care of the SMI population of \$476 million on a recurring basis, a loss of 23 percent. This same decline has been noted in the overall staffing of specialized mental health services.

To reverse this decline in capacity and to address the needed community support program development, the SCMI committee recommended immediate development of several specific evidence-based interventions. First, the VA should implement intensive case management programs sufficient to meet the needs. Second, it should provide access to specialized mental health services wherever possible at the community-based outpatient clinics. And third, it should reverse the decline in substance abuse services, in part by providing opioid substitution programs in large metropolitan areas currently without them.

The committee is fully aware of the resource challenge faced by the VA, especially in light of the unanticipated rapid and enormous increases in lower-priority Category 7 veterans. By our calculations, this population has required a subsidy from medical appropriations of \$747 million in fiscal year 2001.

I see that the light is red. I would like to summarize the rest of my comments by acknowledging that the Office of the Under Secretary has consistently been very supportive of the Special Committee for the SMI and we very strongly believe that that support will continue. It has, however, been difficult to translate some of that support into concrete gains in terms of helping the SMI population in the long run.

We see that there are unmet needs. We need to have a mechanism of identifying what they are, having a plan in place to meet those unmet needs, and we look forward to working with the VA to accomplish that task.

Mr. Chairman, I appreciate this opportunity to share our views and I will be available for any questions you may have.

Chairman ROCKEFELLER. Thank you, Dr. Losonczy.

[The prepared statement of Dr. Losonczy follows:]

PREPARED STATEMENT OF MIKLOS LOSONCZY, M.D., PH.D., CO-CHAIR, COMMITTEE ON CARE OF VETERANS WITH SERIOUS MENTAL ILLNESS

The SCMI Committee appreciates the opportunity to help inform the Senate Veterans' Affairs Committee about the issues raised in your letter of July 3, 2002 in requesting our testimony for today.

I'd like to begin by offering some background on the role of the committee, its legislative mandate, and its composition.

I. LEGISLATIVE MANDATES FOR THE COMMITTEE ON CARE OF VETERANS WITH SERIOUS MENTAL ILLNESS (SCMI COMMITTEE)

Public Law 104-262, section 335, The Veterans Eligibility Reform Act of 1996, established the Committee. This law required that the Secretary of Veterans Affairs, acting through the Under Secretary for Health, "establish in the Veterans Health Administration a Committee on Care of Severely Chronically Mentally Ill [SCMI] Veterans."

The function of the Committee as defined by Public Law 104-262 is to assess the capability of the Veterans Health Administration to "meet effectively the treatment and rehabilitation needs of mentally ill veterans whose mental illness is severe and chronic and who are eligible for health care furnished by the Department, including the needs of such veterans who are women." To accomplish this function, Public Law 104-262 requires that the Committee:

- (1) evaluate the care provided to SCMI veterans;
- (2) identify system-wide problems in such care;
- (3) identify specific VA facilities that need program enrichment in order to improve treatment and rehabilitation of SCMI veterans;
- (4) identify model programs that could be more widely implemented within VA;
- (5) advise the Under Secretary regarding the development of policies for care and rehabilitation of SCMI veterans; and
- (6) make recommendations to the Under Secretary regarding the improvement of care, the establishment of education programs, the research needs and priorities, and the appropriate allocation of resources.

In addition to the section mandating the establishment of the Committee, section 104 of Public Law 104-262 requires that the Department "maintains its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans," including those with mental illness. To fulfill this requirement, the Secretary of Veterans Affairs must consult with the Committee on Care of Severely Chronically Mentally Ill Veterans.

The legislation that mandated the maintenance of capacity for special populations was amended in 1998. The amendments mandated that the Under Secretary develop job performance standards for the VA leadership who have responsibility for the allocation and management of the resources needed for the maintenance of capacity. These performance standards are to be developed in consultation with the SCMI Committee.

Finally, Public Law 104-262 requires that the Secretary of VA submit an annual report to Congress that addresses the effectiveness of VA's treatment and rehabilitation of veterans who are severely, chronically mentally ill. The SCMI Committee releases an annual report in February to the Under Secretary that constitutes the

findings and recommendations to which the Secretary must respond in the mandated report to Congress. Public Law 106-419 amended the original law and extended VA's reporting requirements through 2004.

## II. REPORTING STRUCTURE OF THE COMMITTEE

The SCMI Committee reports directly to the Under Secretary. The Committee publishes an annual report with recommendations in February that is sent to the Under Secretary for his response. The report and the Under Secretary's response are then sent through the Secretary of Veterans Affairs to the Congress.

In addition to the formal mechanism of the Annual Report, the Co-Chairs will typically meet with the Under Secretary after a meeting of the Committee. Or, in some cases, the Under Secretary will attend the actual meeting for a discussion with the entire Committee.

The Committee is also required by Congress to comment on VA's annual report on the maintenance of capacity for the special emphasis populations. The point at which the Committee members receive a draft version of the Capacity Report varies each year. Once the draft is received, the Committee formulates a draft response that is sent to the VA Central Office official responsible for the capacity report. If changes are made in the Capacity Report, the Committee may re-draft its response to reflect these changes. The final response of the Committee is attached to the Capacity Report and sent to Congress.

Finally, the SCMI Committee has a close working relationship with VA Central Office's Mental Health Strategic Health Care Group (MHSHG). The Chief Consultant of the MHSHG and members of his staff serve as consultants to the Committee, but the Committee is independent of them.

## III. COMPOSITION OF THE SCMI COMMITTEE: MEMBERS, CONSULTANTS, AND CONSUMER LIAISONS

The SCMI Committee membership is field-based. The members are professionals from the major mental health disciplines, hold a variety of positions within VHA (both at the facility and Network level), and represent a variety of geographic areas within the VA system. The members of this diverse group, however, have all demonstrated excellence in their respective disciplines and commitment to the service of veterans who are seriously mentally ill. The Committee members are solely responsible for the formal recommendations made to the Under Secretary.

In their work, the Committee members are assisted by consultants from the MHSHG, from the field, and from VA's Serious Mental Illness Treatment Research and Evaluation Center in Ann Arbor. The consultants contribute additional expertise to the Committee, as well as provide essential data on VHA's mental health services.

The Consumer Liaisons are the third component of the SCMI Committee. Early in the life of the Committee, the membership realized that they needed the input and unique perspective of mental health consumers. The Committee asked representatives from the Veterans Service Organizations and from national mental health organizations to attend the Committee meetings, join in the monthly conference calls, and generally to advise the Committee. These representatives from the consumer groups have been articulate voices for those veterans who are seriously mentally ill. This body does not vote on Committee recommendations, which are the sole purview of the members of the Committee.

See Attachment A for a complete listing of Committee members, consultants and consumer liaisons.

## IV. KEY FINDINGS OF THE COMMITTEE IN ITS 2002 ANNUAL REPORT

Your letter of July 3, 2002 asked the Committee to review the findings of the Committee. The SCMI Committee has issued six annual reports. It may be most useful to summarize the most recent report, dated February 2002.

The SCMI Committee has noted for years that there is substantial inter-VISN variability of access to, and intensity of, a variety of MH services. Indeed, the percentage of patients served by VHA who receive any type of mental health service has dropped from 20.3% in FY96 to 17.4% in FY2001. In FY2001 Networks varied widely and unexplainably in the proportion of veterans receiving mental health care, by a factor of 2, from 12.9% to 24.8%. Whether one examines mental health intensive case management (MHICM) programs, MH services in Community Based Outpatient Clinics (CBOCs), opioid substitution programs, or any of a whole host of mental health programs, the inter-VISN variability is marked. Long-term care beds for veterans with serious mental illness are also distributed quite unevenly, with 11 of the 22 VISNs with little or no such beds available. Furthermore, there is no

defined mental health benefits package nationally. These considerations led the Committee to make, as one of its key recommendations this year, the following:

*“VHA needs to develop comprehensive national standards for the required continuum of care for the veteran with serious mental illness and a strategic plan to achieve these standards.”*

#### *Recommendation*

*“A concerted, integrated effort to detail the optimal, population-based continuum of care for the various mental disorders should be completed, under the direction of Patient Care Services Mental Health Strategic Health Care Group (MHSHG), in 2002. The first step should be to delineate VHA’s mental health benefits package. The continuum of care recommendations should include the types and intensity of services that are to be available in areas with various population densities. It should also include recommended measures of productivity for programs and staff in these programs or services. These standards should then be applied nationally no later than FY 2003. Any variance from these standards should be explicitly justified by the Networks and should be subject to approval by the Under Secretary.”*

*Under Secretary’s Comments to this recommendation in the Annual Report:* “Concur in part. The establishment of a population-based continuum of care is an appropriate goal for all VA health care services including our mental health services. VHA policy on the breadth of the mental health continuum of care and the overall benefits package are already in place. Initial needs assessments of mental health services have taken place, and an approach to assessing current services and the range and scope of future needed services is part of the CARES process in which mental health services are a part. MSHSG and other program offices and field representatives of these services will have input into CARES. The Mental Health Strategic Health Care Group will put together a task group to look at research-based evidence regarding productivity standards in mental health programs and to make recommendations to the Under Secretary for Health by December 30, 2002.”

*Status of this recommendation:* The Committee made a similar recommendation to the Under Secretary in its 2001 Annual Report. The Under Secretary responded to this 2001 recommendation by also noting that the Capital Asset Realignment for Enhanced Services (CARES) initiative would be the appropriate vehicle for identification of a continuum of care for mental health services.

The Committee remains unconvinced that the CARES initiative is the proper mechanism to delineate a continuum of care for mental health. CARES conducted its initial project in Network 12. The published implementation process for CARES required adequate input from local providers and stakeholders. However, after the publication of the report on Network 12, the Committee determined that there was actually little input into the project from the Network mental health leadership and other stakeholders. In addition, it appears that the model relies on private sector data, which are not particularly applicable to the population of veterans with serious mental illness. Most private sector health plans attempt to exclude more than minimal contact with such individuals. Furthermore, the actuarial model used in CARES to predict future demand has been notoriously inaccurate in recent experience, since these models predicted declining demand, while actual experience has been increasing demand. The Committee would like to see that the second phase of the CARES project incorporates a more VA-based model, and a real understanding of unmet mental health needs of veterans.

The second major concern of the SCMI Committee has been the lack of systematic development of evidence-based community support programs following the massive deinstitutionalization of the population of veterans with serious mental illness since FY96. The Committee, since its inception, has strongly supported the need for VHA to move away from the heavy emphasis on hospital-based mental health programming. There is a special need to develop programs that successfully transition veterans who have spent long periods of time as inpatients. However, the Committee has always maintained that this can only be properly done by development of a comprehensive array of community support programs, which are not inexpensive, and require time, money and effort to put into place. In 1999, in response to a request from the Under Secretary, the Committee outlined its view of mental health services, with full implementation of a continuum of integrated medical and psychosocial services for veterans with mental illness (see Attachment B).

The need to do such reinvestment of the resources saved by closing inpatient beds into outpatient programs has been recognized by many public programs. In New York state, the 1993 Community Reinvestment Act required 100% of the savings from bed closures to be reinvested in outpatient programs to serve the mentally ill. Similarly, under Governor Whitman, the state of New Jersey has committed to a reinvestment of 100% of the savings into community support development (personal

communication, Alan Kaufman, Director, NJ Division of Mental Health). These states began with substantial outpatient programs before the deinstitutionalization programs of the 1990's, unlike the VA, yet still invested in their continued development. VHA had historically only minimal interest in outpatient programs, until the major reorganization in 1996 fashioned through the Network structure and VERA. Yet, the reinvestment of inpatient into outpatient resources has been substantially less in VHA than in other parts of the public sector.

According to information published by the Northeast Program Evaluation Center (NEPEC), the National Mental Health Program Performance Monitoring System: FY2001 (and FY1996) report (Table 6–8), the reinvestment for the VA can be computed as follows (all dollars in millions):

	Inpatient	Outpatient
\$ spent on services 1996 .....	1,481.7	484.8
\$ spent on services 2001 unadjusted .....	1,133.6	796.3
\$ spent on 2001 adj to 96 .....	850.2	597.2
Change from 96 .....	– 631.5	+112.4

Medical inflation was assumed to be a very modest 25% during this time period (approximately the compounded annual salary increase, and much less than the medical care inflation index for this time period). Thus, the \$631.5 million dollar savings (in 1996 dollars) from closing inpatient beds was accompanied by a \$112.4 million dollar increase in outpatient services, reflecting a reinvestment percentage of 17.8%, which is a very modest reinvestment percentage. In fact, when one considers that the outpatient MH workload increased during this time period by 25% (NEPEC table 5–6), the reinvestment in outpatient care was not sufficient to keep up with the increased demand. There was very little capacity to provide the increase in community support services needed by the outflux of deinstitutionalized veterans. These figures do not include increases in the cost of psychiatric medications, which totaled \$192 million in FY2001 (or \$144 million in FY96 dollars). Since cost data are not available for psychiatric medications in FY96, the increased expenditure can only be estimated. In any case, increases in cost due to medication will not reflect increased community support programs. The major advantage of the newer, more costly medications is the decreased likelihood of tardive dyskinesia, and a change in side effect profile that may be more tolerable for some patients.

It is understandable that VHA had enormous challenges finding adequate funding to meet all of the various needs of the rapidly expanding population of veterans seeking services. Lower priority veterans, who often use VHA for a marginal portion of their health care, for services not covered by their other health insurance options, have been drawn increasingly to VHA services. The number of Category C veterans treated in VHA increased by 964% (almost ten-fold) from FY96 to May 2002. During the first eight months of FY2002 the rate of growth in Category C veterans has continued to accelerate. The number of Category C veterans increased by 46%, compared to the same period in FY2001. In FY2001, only 23% of the costs of treatment for Category C veterans was reimbursed by insurance. The net cost to VHA in FY2001 for the treatment of Category C veterans was \$747 million. During a comparable time period, FY1996 to FY2000, there was a decrease of \$478 million (inflation adjusted dollars) in expenditures for specialized mental health care for veterans with serious mental illnesses. These data suggest that the dollars saved in mental health expenditures were absorbed by the treatment costs of lower priority, Category C veterans. It is not surprising that little was available for reinvestment of saved inpatient dollars into new community support programs to address unmet needs of this high priority group.

This low level of reinvestment is reflected in the ongoing concern by the Committee that the Department has consistently not met the provisions of the capacity legislations laid out by Congress. Since the Capacity Report for FY2001 is still in draft form, the Committee is unable to comment on it, so we will review the Committee assessment for FY2000.

It is important to restate the precise language of the capacity provisions of Public Law 104–262 for reference. That law stated: “. . . the Secretary shall ensure that the Department maintains its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness) within distinct programs or facilities of the Department that are dedicated to the specialized needs of those veteran in a manner that (A) affords those veterans reasonable access to care and services for those specialized needs, and (B) ensures that the overall capacity of the Department to provide such services is not reduced. . . .” The baseline year for deter-

mining capacity is FY96. Public Law 104-262 itself originally did not define capacity. (We note, however, that this law was recently amended to include, among other changes, a definition of capacity.)

The Department, after consulting with the Committee, originally determined that both the number of veterans treated and the dollars expended for their care in specialized programs would be the most appropriate measures for capacity. Capacity could only be maintained if both components were met. It was recognized that mere measurement of the number of individuals served was insufficient, since these patients have broad needs for a full continuum of care, and the mere measurement of the number served could result in providing inadequate service to the same or larger number of patients.

The quality and adequacy of the care required by these special patients also must be measured. The Committee concurred that beds would not be an appropriate measure of quality, since there was the desire to move the care of these patients to the community whenever feasible. It was recognized, however, that comprehensive community care for these very complex patients was also expensive, and that VA had a great need to expand and improve its array of community-based services prior to the deinstitutionalization of the seriously mentally ill. Dollars expended was seen as a pragmatic means to measure the intensity of service provided this special population. The Committee's advice was sought and we concurred that this was a reasonable way to monitor whether the necessary reinvestment of resources from institutional to community-based care was occurring. This measure would be used until valid and comprehensive measures of the outcomes of care for these patients were implemented nationally. As a measure of intensity of service, the Committee believes this is meaningful only if a reasonable adjustment for inflation is included. Over the several years of the capacity report, such an adjustment has become more important. Indeed, the FY99 Capacity Report included in Table 1 inflation adjusted dollars expended on specialized services, in response to comments from the Committee on the need to do so. Subsequently, the FY00 report omits this key information.

Reviewing the summary information for the report, as presented in Table A.1 of the FY00 report, one should only compare the two elements of the definition of capacity above, after appropriate adjustment for inflation. Even without such an inflation adjustment, however, it is clear that the two elements of the capacity definition were not both met for PTSD, the overall SMI group, and most strikingly, for the Substance Abuse population of veterans. They were met for the SMI homeless population. The interpretations provided in this table use the term capacity solely for the numbers of individuals served. These interpretations are at variance with the capacity definition. Based on the data supplied in the FY2000 Capacity Report, the Committee concluded that the Department was still not in compliance with the Capacity provisions of P.L. 104-262. The Capacity report indicates that in FY00 VHA was spending, in unadjusted dollars, only 92% of the FY96 expenditures for the seriously mentally ill. The erosion of financial commitment to these patients, when expressed in terms of constant 1996 dollars, is actually greater, with the Department spending only 77% of the 1996 levels on their specialized care, a further decrease in buying power over last year's report. This reflects an effective decline of \$ 478 million annually. To meet the intent of the capacity law, this amount should be immediately and on a recurrent basis invested in community support development.

To most meaningfully reverse this decline, and meet the intent of the capacity law, the Committee specifically recommended expansion of intensive case management programs, providing MH specialty access in the CBOCs and expansion of opioid substitution programs where need exists. The Under Secretary supported these measures with Directives and performance measures. There has been some expansion of MHICM teams throughout the VHA since then, although these teams appear to have come from redirecting already existing MH resources, and a number of key components of the MHICM directive have not been consistently followed by many programs. Plans have been created to bring MH access into CBOCs and expand opioid substitution programs in the past year, but it is unclear if these will lead to new services in the near future.

On a related note, the Committee noted in its 2002 Annual Report that VERA must be assessed and revised as necessary to assure that the overall funding of mental health cohorts in VERA is in alignment with, and not less than, the overall costs of these cohorts. Funding generated revenue for mental health cohorts that was less than costs by 10% in FY00. This difference is even greater for the subpopulation of the SMI veteran, which was underfunded by 20%. With the difficulties already cited above in establishing a continuum of care for the SMI veteran, removal of fiscal disincentives is a logical and necessary step. The Under Secretary, in his testimony to Congress during the Capacity hearings in June, 2001, committed

to eliminating these fiscal disincentives and to ensuring that the funding model is cost-neutral for the mentally ill. A number of changes have been made in the model, but data are not yet available to determine if the fiscal disincentive through VERA has been removed. Concerns continue that changing the VERA model to another, diagnosis-based model, will need careful scrutiny to ensure that it is at least cost-neutral for mental health cohorts.

Through the years, the Under Secretary has been generally supportive of the recommendations of the SCMI Committee. We have seen major recommendations implemented to

- bring new antipsychotic medications into the VA national formulary
- to develop Mental Illness Research, Education and Clinical Center grants for 8 sites, with the possibility of an additional two sites
- prevent decreases in mental health programs without headquarters approval (Directive 99-030)
- to develop Mental Health Intensive Case Management Programs sufficient to meet the need
- to require VISN plans to bring MH specialty programs to CBOCs except by approved exceptions
- to require VISN plans to implement opioid substitution programs where needs exist
- to develop professional training programs in psychiatric research fellowships, and psychosocial rehabilitation fellowships
- to produce a national satellite broadcast series on recovery for the veteran with serious mental illness

Given the challenge of meeting the needs of the entire, rapidly expanding veteran population, the Committee understands the difficulty of finding resources for the expansion of the needed community support structure for veterans with serious mental illness. Indeed, it may not be fiscally possible without abruptly discontinuing other services, unless there is a major expansion in appropriations. The Committee hopes that VA will find a way to fund all needed medical and psychiatric services for the veterans who have served our country selflessly throughout the years, and who now need service in return.

In summary, the committee is recommending to the Under Secretary that he direct VHA to

- Conduct a national assessment of unmet needs for veterans with SMI, leading to
  - National population-based standards for a MH continuum of care
  - A strategic plan, with appropriate incentives, to eventually achieve these standards
  - Take immediate steps to fully implement MHICM, access to specialized MH services in CBOCs, and ensure access to opioid substitution programs
  - Ensure that the funding model has no disincentives to care for veterans with SMI
  - Reinvest savings from MH inpatient closures to address these unmet needs in community support programs

The SCMI committee wishes to thank the members of the Senate Veterans Affairs Committee for their time and support for these disabled American veterans.

#### ATTACHMENT A.—COMMITTEE ON CARE OF VETERANS WITH SERIOUS MENTAL ILLNESS

##### MEMBERS OF THE COMMITTEE

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 Robert Rosenheck, M.D., National Director- Northeast Program Evaluation Center, VA Medical Center, West Haven, CT  
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 Christine Woods, Program Specialist, Office of the Director, VA Medical Center, Hampton, VA

## CONSUMER LIAISONS

Frances Andrew, Assistant Director of Legislative Affairs, National Mental Health Association  
 Moe Armstrong, National Association for the Mentally Ill  
 Fred Cowell, Staff Director, Health Policy Department, Paralyzed Veterans of America  
 Dr. Frederick J. Frese (alternate representative), National Association for the Mentally Ill  
 Lisa Goodale, ACSW, LSW, Constituency Relations Director, National Depressive Manic Depressive Association  
 Donald Mooney, M.S.W., National Appeal Representative, National Veterans Affairs and Rehabilitation Commission, The American Legion  
 Linda Schwartz, RN, MSW, Ph.D., Yale University School of Nursing, Vietnam Veterans of America  
 Paulo del Vecchio, Senior Policy Analyst, Substance Abuse & Mental Health Service Administration, Center for Mental Health Services  
 Joy Ilem, Assistant National Legislative Director, Disabled American Veterans  
 Rick Weidman, Director of Government Relations, Vietnam Veterans of America

## ATTACHMENT B.—INTEGRATING BIOMEDICAL TECHNOLOGY AND PSYCHOSOCIAL RECOVERY IN THE TREATMENT OF MENTAL ILLNESS IN THE NEW VA

## Committee on Care of Veterans with Serious Mental Illness (9–24–99)

## I. INTEGRATING BIOMEDICAL TECHNOLOGY AND PSYCHOSOCIAL RECOVERY

In the last decade, major advances in the treatment of mental illness have been achieved in both new biomedical technologies and through the development of progressive models for psychosocial recovery. New medications for the treatment of both major mental illness and substance abuse have been thoroughly evaluated and are being widely adopted. In addition, the Recovery model of psychosocial rehabilitation has demonstrated that all people with mental illness, no matter how impaired

initially, can benefit from programs in which their human capabilities are expanded through exposure to appropriate work opportunities and constructive community activity. The VA of the future must sponsor a mental health system which integrates Biomedical advances and the psychosocial Recovery model to maximize the health and well being of veterans with mental illness across the nation.

## II. THE NEW VA

During the past four years VA has reoriented its priorities away from being a health care system based on institutions and towards one that provides equitable service to entire populations. During the next five years VA must further commit itself to the goal of providing appropriate mental health services to all veterans: (1) regardless of where they live (whether they happen to live nearby or far from a VA hospital); (2) to people with mental illness at the same level as to those with physical illnesses; (3) to female as well as male veterans; (4) to minorities requiring culturally sensitive services as well as to whites; (5) to elderly veterans as well as to young veterans in transition from military to civilian life; (6) to veterans with illnesses requiring specialized treatment such as PTSD, substance abuse, psychotic disorders and to the dually diagnosed with co-morbid psychiatric and substance abuse disorders; (7) and to homeless veterans and others with major needs for social support and material assistance as well as for medical treatment. VA's vision for mental health care in the future must therefore be to integrate Biomedical technology and Recovery equitably and systematically for all eligible veterans.

## III. CORE SERVICES

The Under Secretary's Committee on Care of Severely Chronically Mentally Ill Veterans identified nine services in three broad categories that should be the target of developmental efforts in the coming years (Table 1).

**BIOMEDICAL TECHNOLOGY.** Four of these services are in the area of biomedical technology and involve: (1) assuring ready access to crisis intervention and acute hospital care in the event of psychiatric emergency; (2) timely adoption of new pharmacologic agents once their cost-effectiveness has been demonstrated; (3) ready access to basic mental health care in both specialty mental health clinics and primary care clinics, to assure continuity for those with general as well as specialized treatment needs; and (4) comprehensive primary physical health care to address the poor health and high risk of mortality among many people with serious mental illness.

**PSYCHOSOCIAL RECOVERY.** Three additional services fall under the category of psychosocial recovery enhancement. (5) Every veteran deserves humane housing with supports adequate, not only to maintain them in the least restrictive environment, but to encourage improved functioning and community adaptation. (6) Rehabilitation and employment programs must also be readily available not only to maximize functioning, but also to enhance self-respect and dignity. Finally, (7) the active involvement of families and consumers as partners in the pursuit of recovery is fast becoming a standard of practice in progressive mental health systems. VA must seize the opportunity to participate in this development, giving those with the most to gain from the VA a voice in its evolution, and making Recovery a goal for every veteran with mental illness.

**SERVICE INTEGRATION.** Finally, two kinds of special integrative services are needed. (8) Case management is necessary to assure integration and ready access to needed services for the most disabled veterans. (9) Outreach efforts must be mounted to assure access to VA services among veterans who are especially alienated and distrustful, such as homeless veterans, the elderly, and veterans with PTSD who are contacted through the peer-oriented Vet Center program.

## IV. A PLAN OF ACTION

Delivery of premier mental health services in VA can be advanced through a three-stage process.

(1) First, the availability of each of the nine services listed above must be assessed for each geographic area of the country (i.e. for each VISN), as well as for minority groups, female veterans, and veterans in high risk diagnostic groups. Data are readily available on some of the nine service categories (e.g. on Mental Health Intensive Case Management and acute hospital care). However, data will be more difficult to get about others (e.g. housing, residential care). VA should set itself on a course to review its performance, nation-wide, in each of these areas of core service delivery.

(2) Second, in areas of the country, or for sub-populations for whom services are not available at all, or are available at suboptimal levels, action must be taken to fill service gaps, whether in the area of biomedical technology, psychosocial recovery, service integration, or all three. New staff and programs will need to be brought on

line to fill these deficiencies, whether they are internal VA programs or non-VA programs whose availability to VA patients is guaranteed by either informal community partnerships or formal contracts.

(3) Finally, the overall performance and maintenance of each of these nine service domains should be monitored to assure adherence to best clinical practice models and to facilitate flexible transfer of innovations from one part of the system to the others.

## V. CONCLUSION

To deliver mental health care second to none, VA must commit itself to a comprehensive program that fosters the development of services that integrate both biomedical technology and psychosocial recovery, and that provide accessible, customer-focused service of the highest quality across the entire nation.

TABLE 1. INTEGRATING BIOMEDICAL TECHNOLOGY AND PSYCHOSOCIAL RECOVERY IN THE NEW VA: NINE CORE SERVICES

### *I. Biomedical Technology*

1. Crisis intervention/Acute hospital care
2. Advanced pharmacotherapies as they are developed and as their value is demonstrated.
3. Primary mental health care.
4. Primary medical care.

### *II. Psychosocial Recovery*

5. Appropriate Living Environments (Housing, Supported Housing, Residential care)
6. Rehabilitation/Work
- 7 Family involvement/Consumer Support

### *III. Integration of Services*

8. Case management
9. Outreach

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## RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO MIKLOS LOSONCZY, M.D., PH.D.

*Question 1.* According to your testimony, the VA is not meeting the Capacity requirements. If a Congressional mandate and your own Committee's findings are not enough to ensure that VA treats mental health at the same level as primary care, what does the SMI Committee think it will take to ensure parity?

Answer. VA management is highly attuned to the details of the Performance Monitoring system and to the funding allocation model. It is with these tools, used in a more focused manner, that VHA management could positively affect meeting mental health unmet needs on par with primary care.

## THE PERFORMANCE MEASUREMENT PROGRAM

VHA supports its strategic planning process with a Performance Measurement Program, administered by the Office of Quality and Performance Services. Performance Measure compliance is monitored closely and regularly throughout VA, and results are of great interest to Network and Facility Directors. Although certain Performance Measures, such as those for MHICM and for opioid maintenance, have direct Capacity implications, many mental health-related measures do not. In addition, superficial compliance has undermined the intent of certain measures. Thus, recent NEPEC data suggests that many VISNs have implemented MHICM teams in apparent compliance with the Performance Measures, but have inadequately staffed these programs. Plans for insuring access to mental health in CBOCs have similarly suffered from wide variation in meeting the intent of this performance measure. The adequacy of opioid substitution program enhancement plans, in response to that performance measure, has yet to be assessed by the Committee.

Improvements with respect to VA mental health parity would result from (1) increased priority assigned to the mental health-related components of the VA Performance Measure Program; (2) greater involvement of SMI Committee members and VACO Mental Health Strategic Health Group staff in the Performance Measure development process; and (3) VA adoption of Performance Measures that specifically target Capacity issues (i.e., changes in numbers of patients treated, available staffing, etc.). As an example of (3), consider that data from the VA National Patient

Care Database has consistently shown that in recent years a substantial number of VA users carry a psychiatric diagnosis but receive no VA mental health care; nevertheless, it is unlikely that all such patients are in remission or otherwise require no psychiatric evaluation or treatment. A Capacity- related Performance Measure could be developed to monitor facility and VISN rates of untreated veterans with mental health disorders, benchmarked against national annual averages.

#### FUNDING ALLOCATION

VA manages health care delivery in the context of the funding allocation system, the Veterans Equitable Resource Allocation System (VERA). The SMI Committee believes that progress towards mental health parity would be greatly facilitated by appropriate revisions to VERA. Presently, VERA prices only a relatively small group of seriously mentally ill patients in the highest of three reimbursement levels, which has the net effect of under funding mental health patients overall. External reviews of VERA, including the most recent General Accounting Office review, have called for major revisions, particularly with respect to VERA's limited number of reimbursement classes. The two proposed VERA revisions under present consideration result in very large but greatly inconsistent redistributions of VISN funding. Furthermore, neither of the two proposed revisions appears to adequately address VA mental health costs. The Diagnostic Cost Group (DCG) proposed revision is based on a system developed for very different non-veteran patient samples. The DCG-based proposed alternative was thus forced to employ the current VERA patient registry for mental health and other special populations. Consequently, it offers little real improvement with respect to these patient groups.

VERA was from the outset designed to utilize the resource allocation system to support major changes in national policy. The VERA Patient Classification Workgroup should reconsider the current proposed revisions while giving special attention to allocating funding required for maintaining capacity for treating special populations in VA. Specifically, revisions to VERA should consider the large proportion of VA patients with mental health diagnoses (>25%) and the substantial heterogeneity in costs associated with this population. The SMI Committee thus supports the position of several independent reviews suggesting that two or three reimbursement categories do not adequately address the variations in VA health care utilization or costs. Moreover, health services research evaluating diagnosis-based risk-adjustment methods for VA mental health care has recently yielded promising results, which may further support future mental health-related revisions of VERA. If changes in the performance monitoring and resource allocation systems do not promote sufficient Capacity improvements, it may be necessary to consider increased centrally administered specific purpose funding for this purpose.

*Question 2.* VA is embarking on an expanded effort to “restructure and realign” how VA delivers services—the CARES effort. How will the CARES process take into account the needs of the seriously mentally ill, now and in the future?

*Answer.* CARES represents a bold strategic planning effort to align VA's resources in a manner so as to optimize provision of veterans health care in the next twenty years. Considerable effort has gone into developing quantitative models to project system demand over this time period. The Committee remains concerned, however, that despite the wealth of modeling data and projection assumptions already established for this project, there remains no, explicit, quantitative plan to account for the VA mandate to care for special populations, in particular those with serious mental illness.

In the most recent description of the CARES planning model (CARES Guidebook, Phase II, June, 2002, p. 43), it is acknowledged that the actuarial consultant “did not model special disability programs”. While there is a mention that “mandated levels (of utilization) will be substituted as needed” to ensure capacity maintenance, the Committee feels that, given the expedited nature of the CARES project, this lack of detail this late in the process is inadequate; it is critical that the appropriate modeling for this be developed immediately, so as to ensure adequate input/feedback from VA Mental Health leadership and other stakeholders before development of final plans for each VISN. Such modeling must explicitly take into account not only capacity requirements, but an accounting for the patterns of veterans mental health care utilization (for which there are not good correlates in the private sector models used by VA's actuarial consultant), e.g., need for a robust continuum of care and need for access which is more in line with that expected for primary care rather than specialty care, given the vulnerability of this population. The reliance on extrapolating recent trends in utilization also has potential pitfalls. There is wide variation in mental health program development and elaboration throughout the country. On top of that, the variation in utilization trends is also substantial. Using

these trends, rather than a population based needs assessment, risks projecting future needs on highly variable historical commitments and declines.

Given the Committee's concerns, we have undertaken to engage the VA CARES leadership in a collaborative effort to correct what we believe to be a substantial problem in the CARES planning process. To ensure this problem is remedied consistent with the timeline for the CARES process, we strongly feel that a focused task force, made up of both VA Mental Health and CARES personnel should be immediately charged by the Under Secretary with explicitly defining the modifications to the CARES models required for an adequate accounting of special populations. We have already expressed our grave concern at the ongoing erosion of VA's resource commitment to the care of the seriously mentally ill. We are concerned that without a vigorous addressing of the CARES issue, the erosion could escalate further under the auspices of a strategic plan, which inadequately accounts for a major priority of VHA.

*Question 3.* Your network (VISN 3) has been particularly challenged by the influx of higher-income veterans. As this has occurred, are services for veterans with mental illness unequally targeted for cuts?

*Answer.* To address this issue, I'd like to share my personal view of some of the defects in the VERA model, which is used to determine resource allocation at the VISN level, but without any significant guidance as to how that allocation is further distributed within the VISN.

First, the VERA model intentionally causes massive under funding of long-term care. There are three large categories of long-term care used in the VA nationally: (1) nursing home beds (2) long stay patients in mental health and (3) intermediate medical beds. If a patient stays an entire year, VERA causes the facility to lose about \$70,000 per veteran, even after factoring in the higher reimbursement of the complex care category. This is an enormous disincentive to provide this level of care. Indeed, there have been very substantial reductions in this level of care. Nursing home advocates succeeded in convincing Congress to require VHA to maintain at a VISN level the number of nursing home beds existing in 1998, when it passed the Millennium Bill. The dual impact of the VERA model and the Millennium bill posed special challenges for VISN 3.

Historically, there was very wide variation in the development of long-term care beds throughout the country. In 1996, VISN 3 had the highest number of patients in such beds, accounting for 50% of its total costs. These long-term beds reflected the historical investment in developing both nursing home beds and mental health beds, including the largest number of long stay mental health beds in the country. The immediate impact under VERA was to put VISN 3 under the largest funding deficit in the country. In my view, there should have been a thoughtful estimate of surplus beds and/or unmet needs for both nursing home and mental health beds in all VISNs throughout the country. This would allow the resource model driving a set of clinical standards based on need, not history. Furthermore, when there is a large variation of current costs and VERA guided reimbursement, there should be a planned transition period that adequately takes into account the time it takes even highly efficient planning to radically alter existing distribution of programs. Instead of this more measured approach, VHA simply placed a cap on the amount of loss any one VISN would need to sustain, but the overt view was that the need to place a cap was the result of poor management performance, not due to an inevitable time lag for massive program change (or even undesirable program change).

Second, whether through oversight, design, or another inertia of history, VERA does not adequately adjust for geographic cost variation, in my opinion. The VERA adjustment for labor and contracts significantly under-reimburses VISN 3 for medical care. Included in the costs of medical care in NY are not only salary costs but also items like fuel and utilities and contracts. The relative lack of geographic adjustment in VERA is underscored by examining how this issue is handled in other federal health care reimbursement structures. For example, the HCFA reimbursement for DRG 430 (Psychosis) is 50% higher in the NY metro area than the national average. VERA makes no such adjustment. It is hard to understand why the federal government would be willing to have such a large geographic adjustment to reimburse public and private facilities through its far larger HCFA budget, but VA would use a very different standard. As you know, VERA does not reimburse for Category 7 veterans, the assumption being that these veterans are not poor. Whereas this may hold true in some rural parts of the country where an annual income of \$24,000 a year is considered a reasonable means test cut off for Category 7, in NYC an individual making \$24,000 is considered impoverished. Indeed, the HUD definition of very low income identifies \$29,050 a year for a single person in the VISN 3 area, while the same definition in the south can be more than \$10,000 less. As a result, many category 7 patients in NY are more similar in medical and social

needs to Medicaid patients living in poverty than to middle class patients, yet VISN 3 receives no reimbursement for these patients because of the lack of adjustment for the means test. In addition, these impoverished veterans are penalized by having to pay a co-payment for care. The rationale for a meaningful regional adjustment is particularly clear, in my mind, when one considers the income levels used to establish the critical boundary between category 7 veterans and higher priority categories.

As the SCMI Committee testimony makes clear, category 7 veterans cost VISNs (and the VHA) substantial sums, so the definition of the income boundary for this category is crucial. The basic notion of this group is that they are not service connected and are not poor. One would think that any rational definition would take into account the fairly large variation in cost of living from one part of the country to another. A veteran earning even \$10,000 dollars above the current category 7 boundary in VISN 3, a very high cost area, would face far higher housing costs, and many other living costs, than the veteran in the part of the country with average living costs, or even below average costs. Yet there is no geographic adjustment in definition of category 7 vets that takes this key factor into account. This means that instead of being reimbursed by VERA for the veterans in this marginal income group, VISN 3 is obligated to lose substantial sums on the care of these veterans.

There are other, less obvious, impacts on clinical practice of serving in this area. Low-end housing costs (on which the vast majority of psychiatric patients are forced to rely) are much, much higher in VISN 3 than most other parts of the country. This makes it more challenging to have a range of alternatives available to assist veterans when they are homeless or have lost their housing during an inpatient admission. Rent alone, even at the low end, can be higher than income available to some veterans. This has a tendency to increase lengths of stay and hospital costs, relative to an area with a much lower low-end rental market.

Finally, when Congress passes legislation requiring a specific distribution of services within the VA, but does not require the adjustment of VERA or the overall total VHA budget to reflect the impact of such legislation, it can pose special challenges for affected networks. Indeed, such was the case with the Millennium legislation. Since VISN 3 started with one of the most significant commitments to providing nursing home beds, passage of that legislation had a greater effect for VISN 3 in requiring it to provide a higher level of service than the national population-based average for a very costly service. From my point of view, VERA needs to be properly adjusted when legislation removes fiscal control from VISN managers. Naturally, the issues raised above affect not only VISN 3, but also many other VISNs as well to lesser degrees.

Given the above considerations on issues outside the control of VISN 3 managers, the massive projected shortfall for VISN 3 year after year after year, forced VISN 3 to cut or redesign services wherever it could safely do so. Historically, VISN 3 had enjoyed one of the greatest investments in providing mental health services of any network. However, the network mental health services were too heavily invested in inpatient-based care, and had incompletely developed community support programs. Nevertheless, compared to other VISNs, even in 1996, VISN 3 had MHICM programs (then called Intensive Psychiatric Community Care) at 4 of its 6 sites and relatively intensive day treatment programs at most sites. The continuing budget contraction made it very difficult to reinvest any significant fraction of savings from inpatient services, but both Lyons and Northport were able to create new MHICM teams from a partial reinvestment. The commitment of the VISN to maintaining high quality mental health services as feasible under its budgetary constraints was visible from its inception. The VISN CEO, Mr. Jim Farsetta, has a long history of involvement and support for mental health (he is on the Board of Trustees for Rockland Psychiatric Center, a New York State facility, for example). One of his first VISN-wide initiatives was to charge a VISN level mental health leadership group with improving and coordinating care. Homeless services, critical in the expensive New York metropolitan environment, have significantly expanded under his leadership, and that of Ms. Henrietta Fishman, the first VISN service line coordinator. It is also the first VISN to monitor the outcome of the significant numbers of veterans deinstitutionalized during this period, and can accurately assert that they are doing well and are successful in the community. Given the very small flexibility in VISN 3 to act in this environment, it is my impression that the cuts were fairly equally distributed among the various clinical services. If VERA had been more fairly designed, the budgetary pressure to reduce staff would have been substantially less, and there would have been more flexibility in developing new community support programs to address unmet needs.

Senator JEFFORDS. Mr. Chairman, I have to leave. I just wanted to thank the——

Chairman ROCKEFELLER. Did you want to ask questions, Senator Jeffords?

Senator JEFFORDS. I have got to start another hearing. I appreciate the opportunity to be here and certainly want to do anything I can to help you, Mr. Chairman, take care of their problems. Thank you.

Chairman ROCKEFELLER. Spoken like the good veteran you are. [The prepared statement of Senator Jeffords follows:]

PREPARED STATEMENT OF HON. JAMES M. JEFFORDS, U.S. SENATOR FROM VERMONT

Mr. Chairman, I would like to thank you for holding this important hearing. Some would argue that mental health services have a relatively low profile in the VA. In my mind, however, they are among the most important services the VA can provide to this nation's veterans. Veterans will tell you that they travel great distances to go to a facility that appreciates their unique status as a veteran and treats them with corresponding respect. This special feeling of being valued and being understood is of paramount importance when it comes to treatment of mental illness. The VA is the right place to deliver this care. It has some of the nation's top mental health expertise, years of clinical experience, and most importantly, the VA has the trust of veterans. It is high time that the program was provided the funding it needs and the attention that it deserves.

While we will not have time to focus specifically on PTSD treatment and research today, I would like to bring to my colleagues attention the important contributions of the VA's National Center for Post-Traumatic Stress Disorder. This center, headquartered in White River Junction, Vermont, is dedicated to improving the quality of VA treatment provided to veterans with PTSD. The Center's research, educational, and consultation activities have unquestionably promoted better clinical treatment for veterans with PTSD. The center has made significant contributions to our scientific understanding about the causes, diagnosis, and treatment of this potentially incapacitating disorder that affects thousands of service-connected veterans. The Center has been innovative in its efforts to get information about PTSD treatment into the hands of practitioners, who can put the information to use with patients. For example, the Center has developed some unique resources for mental health professional, such as an award-winning website and the largest and most comprehensive bibliographic database in the world, called PILOTS, the Published International Literature on Traumatic Stress.

As a central authority on PTSD, the National Center has frequently served as a consultant to VA policy makers as well as other governmental and international officials on matters concerning treatment programs and practices. The Center has played an important role in developing practice guidelines for individual treatment and for early intervention following major disasters. Detailed information on the Center is included in its latest Annual Report, which has already been distributed to members of this Committee.

I wanted to take this time today to acknowledge the important work of the VA's National Center for PTSD. Strong support for this Center is an important part of any effort to improve VA mental health care and improve treatment for veterans with PTSD.

Mr. Chairman, once again, I appreciate your holding this hearing today. I hope that these efforts will highlight the areas where improvements must be made, and underline the critical importance of doing so immediately. I apologize for not being able to stay for all of the testimony, but I am chairing a hearing of the Environment and Public Works Committee in just a few moments, but I will be interested to hear what comes of your discussion.

Chairman ROCKEFELLER. I am glad to hear that veterans with mental illness have the full support of the Under Secretary, but I would like to see more concrete results. That is the essence of oversight, it seems to me. In other words, there is no question that Dr. Roswell is supportive. What the veterans care about is results. And between the Washington words "supportive of" and the services provided—the concrete results, is the difference.

You used the words “aggressive case management,” or “intensive case management,” did you not, in your testimony?

Dr. LOSONCZY. Yes, we both did.

Chairman ROCKEFELLER. I would like to understand what is meant by that. What needs to happen in intensive case management of an individual veteran with a mental health problem? Dr. Roswell, then I would like you to say what you think this means, and what it is that you can and cannot do to make it happen.

Dr. LOSONCZY. Intensive case management in the sense that the committee has used the word is also called assertive community treatment and is a well studied, evidence-based process that clearly is effective in many ways for the seriously mentally ill. But let me just underscore that this is not a treatment that is designed for everybody, not even everybody that is seriously mentally ill. It is a treatment that is designed for those people that have particular trouble accessing services on their own, who spend a lot of time on the inpatient side, in part because they have trouble accessing outpatient services, who require rehabilitation efforts in order to be able to achieve their best potential.

The way that the MHICM, or intensive case management model has been adopted in the VA is a modification of the evidence-based ACT programs in the community. They are multi-disciplinary by definition. An intensive case management team can have no fewer than four members. It should have a psychiatrist, a psychologist, a social worker, a nurse, ideally a rehab specialist. For the intensive case management to work effectively, it should focus on what the veteran is able to do, what the reasonable goals they can agree with the veteran on achieving, and to develop an effort to achieve them.

Chairman ROCKEFELLER. Can I stop you there and then turn to Dr. Roswell. Just tell me, and obviously there are variations across the country, but what is it that VA could do to meet that standard and what is it that VA cannot do to meet that standard.

Dr. ROSWELL. I agree with everything Dr. Miklos Losonczy said, but Mr. Chairman, the key of assertive community treatment is the interdisciplinary team that Miklos spoke of, a psychologist, a psychiatrist, a psychiatric social worker. There are basically two main therapeutic approaches—

Chairman ROCKEFELLER. No, no, I asked a question. I understand what he said and I understand what you are saying. What I am asking is how well and how consistently do you meet that standard?

Dr. ROSWELL. We meet it inconsistently.

Chairman ROCKEFELLER. This is the difference between support and concrete results.

Dr. ROSWELL. We meet the standard inconsistently. We do have over 65 of these programs in place and others are being developed.

Chairman ROCKEFELLER. Sixty-five covering how many?

Dr. ROSWELL. We have over 1,200 locations of care.

Chairman ROCKEFELLER. So what kind of statement is that?

Dr. ROSWELL. Where I was trying to go is that mental health care for the more serious mental illness is resource-intensive. It requires an interdisciplinary team, but one of the modalities is psychotherapy. Psycho-social readjustment involves a lot of close inter-

personal interaction between patient and clinician, and an interdisciplinary team, such as the community case management model that we are speaking of, to be efficient, has to have a critical mass of at least 30 to 40, possibly 50, patients to be able to utilize the talents and capabilities of the professions involved in the interdisciplinary team.

So the difficulty is placing that kind of expertise at so many distributed locations of care. Our typical community outpatient clinic has a physician, two or three nurses, and a couple of support staff. So to try to put in a team of four mental health professionals in that location would be extremely resource-intensive, and then if we were to do that, we would find that they would not have the patient population that supported—

Chairman ROCKEFELLER. And I understand that. Excuse me for interrupting. So, in effect, in these 1,200 locations—and, of course, some of those are outpatient, as you have indicated, what is the degree of your effectiveness? It sounds like a shortfall, and if it is, I do not want to criticize you for it.

Dr. ROSWELL. It is a shortfall, Mr. Chairman. It is hard for me to characterize the magnitude of the shortfall, and again, I think that is where we have to do a better job of needs assessment, as was mentioned. I think the mental health improvement plan allows us to begin to more accurately assess what the actual needs are.

Chairman ROCKEFELLER. Can you do your assessment? But then is the money, this thing that Senator Wellstone said about what to put back into the budget. Is the money going to be available, regardless of what your assessment comes out to be? Are you going to be able to do it, or is it one of these constantly elusive Washington goals?

Dr. ROSWELL. Obviously, we are struggling with a tremendous demand for resources and the reinvestment that Senator Wellstone spoke of is low, partly because we believe that the way we can provide mental health today, including the type of model we are speaking about, is less costly and, therefore, should generate savings that can be used to provide a more comprehensive spectrum of mental health services for veterans.

Chairman ROCKEFELLER. That is interesting. Your statement it is very honest. But what you are, in essence, saying is that you want to be able to do more, but cannot.

Plus, you do not really decide your budget, nor do we in this committee. That decision is made by the Appropriations Committee, the White House, and OMB. You cannot come here and say things that you may want to because of OMB. We understand that.

Dr. ROSWELL. Yes, I know.

Chairman ROCKEFELLER. So when you say that we have to cover the full spectrum of health care needs, that is a statement about mental health priorities. I am just putting that out for you to ponder. What kinds of things might happen if you focused more on mental health?

Dr. ROSWELL. Well, today, there are over 300,000 veterans across this country who will have to wait 6 months or more to receive care that they were told they would be eligible to receive. That causes me a tremendous concern. Many of those veterans who have come

into our system just within the last couple of years after the system was opened to all veterans, beginning in October 1998.

There are higher-income veterans, the Priority 7 veterans, who do not have service-connected disabilities and do not have special needs, such as serious mental illness. Many of them are coming to the VA for the first time ever to seek prescription benefits to augment their current Medicare coverage. It is difficult to manage that kind of demand for care and the political pressure it generates.

I can tell you, though, that as we are aggressively studying this population and attempting to manage the problem, I can provide some preliminary reassurance that the large numbers of new veterans who are seeking care through the VA do not have a high prevalence of serious mental illness. Rather, the prevalence of serious mental illness seems to be greatest in our core population, as one would expect it to be.

So on the one hand, we are challenged by the demand for prescription medications and less complex care that is created by the new demand of an open enrollment system, and by still assuring that we meet the needs of the seriously mentally ill veteran population, whom we have historically served and will continue to serve, albeit now on an outpatient basis.

Chairman ROCKEFELLER. OK. On April 3, 2002, there was a letter written to Secretary Principi by many veterans' service organizations and by mental health advocates. They would want to see complete coverage of mental health care. That letter will be made part of the record.

[The information referred to follows:]

*April 3, 2002.*

Hon. ANTHONY J. PRINCIPI,  
Department of Veterans Affairs,  
Washington, DC.

DEAR SECRETARY PRINCIPI: As organizations concerned that this nation meet its commitment to veterans with mental illness or substance abuse disorders, we are writing to express our grave concern that the Department of Veterans Affairs (VA) health care system is failing to comply with its statutory obligation to provide needed services to these veterans.

That obligation, expressly codified in law (at 38 U.S. Code section 1706(b)), directs the Secretary of Veterans Affairs to provide for the specialized treatment and rehabilitative needs of veterans with mental illness and substance use disorders through distinct programs and facilities dedicated to their specialized needs. The law requires the Secretary to ensure that the overall capacity of the Department to provide those specialized services is not reduced below the capacity in place in October 1996, and further directs the Secretary to afford veterans who have a mental illness reasonable access to care for those specialized needs.

A review of the legislative history underlying this law shows that Congress imposed the requirement that VA maintain the capacity to provide specialized services through dedicated programs because of a concern that fiscal pressures associated with a then-proposed reorganization of the Veterans Health Administration might lead administrators to close or shrink these often-costly programs. Those concerns have regrettably been borne out. A special committee, chartered in law and charged both with overseeing the quality of care afforded veterans with severe mental illness and with monitoring adherence to the requirements of the "capacity law", has advised the Under Secretary for Health on its findings. For the last four years that expert committee has reported that "the Department has not maintained capacity for veterans with serious mental illness" (including those with substance use disorders).

Disturbed by the Department's failure to comply with this statutory mandate, Congress has twice amended the "capacity" law, most recently in Public Law 107-135. In those recent amendments, Congress was clear in delineating VA's statutory responsibilities under the law. First, it amended the capacity law to make explicit

that the requirement to maintain capacity is not simply a VHA-wide obligation but one that applies to each of the 21 Veterans Integrated Service Networks (VISNs), rejecting some VISN officials' view that this law is "someone else's responsibility". Second, it made explicit that the Department could not employ outcome data to meet the requirement to maintain program capacity, rejecting the notion that satisfactory patient outcomes would satisfy the law. Third, it delineated what the term "capacity" means for various specialized mental health programs. Congress employed very specific, objective measures, requiring VA to maintain funding levels, program levels, staffing levels and patient workload. Finally, the law calls on the VA's Inspector General to ensure through its independent audit function that these requirements are carried out.

With VA's failure—both nationally and in many networks—to maintain its precious specialized program capacity to serve veterans with mental illness and substance use disorders, Congress has directed VA to eliminate the gap between the mental illness and substance abuse program capacity that existed in 1996 and the much-diminished capacity in place today. This law requires nothing less than that VA expand substantially the number and scope of specialized mental health and substance abuse programs so as to afford veterans real access to needed specialized care and services.

We see no evidence, however, that the Department has absorbed the import of section 1706(b) of title 38, U.S. Code, as amended. We note with dismay that the budget is silent regarding both the capacity law and the steps VA proposes to take to meet its requirements. Since 1996, VA's record of compliance with this law has been limited to the mechanical act of compiling and submitting reports. The capacity law is not principally about reporting to Congress, and the submission of further reports—without accompanying program expansion—will not satisfy its mandate. It is about allocating appropriate resources to meet an explicit statutory requirement.

The Department's failure to allocate the necessary resources, or even budget for them, is inexplicable and indefensible. This failure is all the more disturbing when one considers the high percentage of veterans with severe mental illness who are service-connected for that illness.

We ask, accordingly, that you advise us, and the appropriate committees of the Congress, of your plans for carrying out these responsibilities.

Sincerely,

AMERICAN PSYCHIATRIC ASSOCIATION  
 AMVETS  
 DISABLED AMERICAN VETERANS  
 FREEDOM FROM FEAR  
 MILITARY ORDER OF THE PURPLE HEART INC.  
 NATIONAL ALLIANCE FOR THE MENTALLY III  
 NATIONAL DEPRESSIVE AND MANIC-DEPRESSIVE ASSOCIATION  
 NATIONAL MENTAL HEALTH ASSOCIATION  
 PARALYZED VETERANS OF AMERICA  
 THE AMERICAN LEGION  
 VETERANS OF FOREIGN WARS  
 VIETNAM VETERANS OF AMERICA

Chairman ROCKEFELLER. These groups say that the VA health care system is failing to comply with its statutory obligation. So what I would like to get each of you to do is to help me understand the discrepancy.

Dr. ROSWELL. Well, I believe the statutory obligation refers to a statutory requirement to maintain our serious mental illness capacity at 1996 levels. In fact, we have just completed our capacity evaluation and examined the number of veterans who are currently receiving care and I am pleased to report that the most recent capacity report data show that, in fact, we have increased capacity slightly since our 1996 levels. So in the strict sense of the law, we are meeting our statutory requirement.

Now, having said that, does that fully address the mental health needs of our population? I think not, and I think that our challenge is to make mental health services available at all locations of care, including our community-based clinics, recognizing that management of serious mental illness in those locations is not optimal.

Therefore, we have to address the kind of models that Dr. Losonczy spoke about and try to have those distributed as best we can, recognizing that they will not be available in all locations because of the intensity in resources.

We are working to use distance technology, telemedicine, if you will, to enhance telepsychiatry in outlying locations. We are using clinical practice guidelines. We will be focusing on primary care provider education and support mechanisms to enhance their ability to provide care to less seriously mentally ill veterans in outlying or community locations, and we will continue to focus our efforts on building the MHICM's, the Mental Health Intensive Case Management programs, in areas where the numbers of veterans who would benefit from that type of care are sufficient to justify their creation.

Chairman ROCKEFELLER. I want to ask you also, Dr. Losonczy, to respond to that, but I also want you to respond to something Dr. Roswell just said about telepsychiatry. I do not know, as a lay person, whether—psychiatry is usually in person. Historically it is very much a one-on-one, physically present type of service. Does telepsychiatry interrupt that intimacy, or does telepsychiatry take away a little bit the discomfort that one has in discussing inner problems.

Now, just as Dr. Roswell said, that is a very interesting thought, and I want you to, first, answer the question which I asked him, and then second, respond to what I just said.

Dr. LOSONCZY. Can I do the second one first?

Chairman ROCKEFELLER. Yes.

Dr. LOSONCZY. OK. Telepsychiatry is a relatively new intervention, and when I first heard about it, I had some trepidation along the line of the need for human contact in order for it to be effective, and I think there are definitely individuals for whom it does not work as well due to the lack of human contact.

But we have had some experience directly with it ourselves and we did patient satisfaction surveys on both staff and on the patients in some small pilot efforts and found that, in fact, we had no problem from the patients' perspective of being able to see a therapist on the other end of the TV screen. We did have some staff who had been trained in various models that found it unsettling and said they would miss some subtle cues that they would be able to tell in person.

I think the jury is out. There really have not been large-scale comparison trials, to my knowledge, about the effectiveness or deficits of telepsychiatry. My guess is that it is going to turn out to be fine for a large number of people, and then we will probably understand better for whom it will not be fine. Does that answer your telepsychiatry question?

Chairman ROCKEFELLER. It does.

Dr. LOSONCZY. On the issue of how is it that the department and the special committee can look at the same set of data and have exactly opposite conclusions, historically—my understanding is this year's capacity report is still in draft form, so we are only talking about previous years' reports.

In previous years, the interpretation of the department about the twofold definition of capacity was different from the committee's.

The twofold components are that the number of veterans served in a specific diagnostic group, and there are four of them for SMI, and the dollars expended for their care would be at 1996 levels.

Now, when the committee was consulted in this definition and agreed upon—in fact, I strongly urged the committee to agree on this because we did not want to limit the ability of the VA to be creative in the way they configured mental health services. We knew that the current configuration was wrong in 1996. However, when we had our discussions with VA representatives, we also saw that in a year, 2 years, 3 years, 4 years, with inflation being present, that the only logical definition of resources expended would include an inflationary adjustment.

So the committee has always included an inflationary adjustment in its evaluation. The VA 1 year did and other years has not. So that is essentially the source of how could it be that two well-meaning groups looking at the same exact data come to diametrically opposed conclusions.

Chairman ROCKEFELLER. I will accept that without comment for the moment, but I need to think about it.

Dr. Roswell, Dr. Losonczy highlights that there has not been adequate reinvestment in outpatient care after the massive closure of beds. Adjusting for inflation, VA only reinvested 18 percent of the savings from the closures into additional mental health outpatient treatment. Where did all this money go? Senator Paul Wellstone brought this up, and I want you to tell me where the money went, because it obviously did not go to mental health.

Dr. ROSWELL. In 1996, VA was treating about 2.9 million veterans each year. This year, the VA will treat 4.6 million veterans.

Chairman ROCKEFELLER. You mean in general?

Dr. ROSWELL. In general. I am talking about all veterans.

Chairman ROCKEFELLER. Yes.

Dr. ROSWELL. Within the 4.6 million veterans who will receive care from VA this year, the percentage of veterans with serious mental illness—is, we believe, less, even though the actual number has increased. So the growth has been disparate across our system between the growth in demand for mental health services and the overall growth in demand for all types of care and services.

During this same time period, VA shifted from a delivery system that was primarily 172 hospitals to an outpatient delivery system that now includes over 600 community-based outpatient clinics in addition to our hospitals.

Chairman ROCKEFELLER. I am going to interrupt again, and I apologize. What do you mean by “less”?

Dr. ROSWELL. I said percentage, and I am sorry if I disconnected that. What I am saying is that the number of veterans who today require and receive mental health care services from the VA is greater, but the growth in veterans in need of mental health services is not as great as the overall growth in veterans seeking some type of care from VA. Most of the growth comprises Priority 7 veterans for prescription benefits, and that has put tremendous pressure on us to utilize any available resources to meet that growing and burgeoning demand for care, as opposed to reinvesting in historical programs.

As I said earlier, intuitively, I believe that shifting a delivery model from an inpatient basis to an outpatient basis should generate cost savings per individual treated. I believe there is substantial data that support that. The question that I have tasked some of my staff with, including the special committee, is how do we assess the veteran population and truly determine what the needs are and how effectively we are meeting those needs, because I do not believe our mental health capacity should be measured in dollars. I do not believe it should be measured in inpatient beds. I do not believe it should even be measured necessarily in the number of veterans treated.

Rather, it should be measured based on the population of veterans we serve with data systems and with whatever mechanisms we have at our disposal to determine the absolute total need within that population and then measure how close we are coming to meeting that entire need.

And sir, we are not there yet. But as a system, we are using the talents, the resources, the technology and our capability to move us closer to that goal.

Chairman ROCKEFELLER. What percentage of veterans with mental health problems, self-identify as such?

Dr. ROSWELL. As a non-mental health physician, I would answer that serious mental illness is usually evident. Our outreach programs, particularly with the homeless population, where we have an underserved population of veterans with serious mental illness, is very important because they may not seek care. But if they do seek care, serious mental illness is usually evident.

Where we are focusing on reaching out to identify mental health needs is in the less-serious mental illness, including depression screening, which is now a performance measurement monitoring system at all of our community-based outpatient clinics. We believe that all primary care providers should be screening patients for depression unless there is mental illness, but I will certainly defer to Dr. Losonczy for his comments.

Dr. LOSONCZY. The Chairman asks a very interesting question and it really goes to the core of the insight that people with serious mental illness have about the fact that they have such an illness. There is work by Javier Amador, who is a psychologist recently moved to the evaluation staff of NAMI, who has examined the degree to which people with schizophrenia understand that they have symptoms and there is about 40 percent of the population with serious mental illness that do not have insight into the fact that they have that, and they are particularly challenging to treat, as you can imagine because they do not usually come knocking on the door and saying, "I would like your help, please."

Dr. Roswell is also pointing out that if a clinician were to see them, it would be evident that they have serious mental illness.

Chairman ROCKEFELLER. To the clinician?

Dr. LOSONCZY. Yes.

Chairman ROCKEFELLER. I have used this example before, but I can remember going to a couple of outpatient clinics in West Virginia. There were receptions going on, and there were people in this case, relatively young men in coats and ties. I thought that

they were local elect officials that I had not yet met. It turned out that they were there for post-traumatic stress disorder treatment.

It was very interesting to me, and ever since then, I've wondered, when was it that they discovered their illnesses? Was it they who discovered it, or was it a family member who discovered it. There is such denial on mental illness and also a lack of understanding. Therefore, there is pressure on VA to be more proactive.

Dr. LOSONCZY. Would you like me to respond to that?

Chairman ROCKEFELLER. Please.

Dr. LOSONCZY. PTSD is a very separate illness, of course, from schizophrenia and it has a long history of different names throughout civilization. It is only very recent that it developed the PTSD name.

Chairman ROCKEFELLER. What was it called previously?

Dr. LOSONCZY. War stress, people have felt that there was battle fatigue, there was a whole host of names for it—

Chairman ROCKEFELLER. OK. I understand.

Dr. LOSONCZY. But the full syndrome was really only described, I think, in the 1970's, Larry, is that right?

Dr. LEHMANN. 1998.

Dr. LOSONCZY. 1998, even later than that. I think that it is fair to say that education of the public has been critical for the ability of family members and patients themselves to be able to self-identify PTSD. It is much more challenging to identify PTSD by a clinician who does not have a patient automatically reporting these symptoms to them than to identify serious mental illness, a psychotic individual.

In fact, in the older population, World War II and the Korean veteran population, there is much less awareness and knowledge about the symptoms of PTSD, although it is now beginning to come out, and we are seeing a growth in the older individual that has been diagnosed with PTSD but probably had it since the war.

Chairman ROCKEFELLER. Yes, sir?

Dr. LEHMANN. Just a few additional comments on that. One is that the way you saw those gentlemen at that meeting, their deportment, their clothes, and their demeanor, is an evidence of the fact that the positive impact of treatment on individuals who do come for treatment for PTSD and it is treatable and people can improve.

I think that one of the things that we are finding—the information that Dr. Roswell passed on, we have increasing numbers of veterans who are coming to us for care for PTSD. Of those 57,000 who are seen in our specialized PTSD programs, about 20,000 of those folks were people who had not been seen in those programs before. So they are coming in increasing numbers, and about 11 percent pretty regularly tend to be individuals from World War II, Korea, and those populations, and about half of the people who we see in our general mental health programs for PTSD are people who are World War II/Korea, largely because the specialized PTSD programs were initially set up for veterans from the Vietnam era.

But we are not only doing screening for major depressive order in primary care. We are doing that, but we are also doing screening for PTSD and other stress disorders. We have developed an educational program as part of the Veterans' Health Initiative for the

recognition and understanding of PTSD in primary care settings and looking at the things one can do either in primary care or enhancing the referral capabilities for individuals who have PTSD and need referral, to specialty mental health treatment.

And in addition, we have mentioned a couple of times the clinical practice guidelines. VA actually developed the first PTSD clinical practice guideline as part of our original depression practice guidelines, one of those modules, and primary care clinicians, as well as those from Readjustment Counseling Service, were part of that project team. I actually headed that project team.

Right now, as a matter of fact, 2 weeks ago, over in Virginia, we started work on a new stand-alone PTSD practice guideline that included staff from the National Center for PTSD, members of the Under Secretary's Committee on PTSD, clinicians from Readjustment Counseling Service, and colleagues from all the branches of the Department of Defense.

Chairman ROCKEFELLER. I thank you.

On the legislative side, our job is to make sure that all kinds of health care needs are covered. This then has to become consistent with our willingness and your willingness to fight for a budget to get it all done. This is obviously quite difficult when you start out with an enormous budget deficit for the next 10 years. But our job is to take care of veterans.

So with that as a framework, Dr. Roswell, I would be very appreciative if you would give to this committee what it would cost for quality mental health care. Not to do the 65 multi-disciplinary teams and stretch them too thin, but what it would cost to do mental health care properly, as you previously described.

One of the reasons I am going to ask that is because I do not know for sure if you can give me that figure. If you will be allowed to give me that figure. Either way, I want that to become part of the public record. Do you understand? That is in your interest as well as my interest. If OMB says, "no," you cannot do that, then you can tell me. Would you be willing to do that?

Dr. ROSWELL. Mr. Chairman, I would be willing to attempt to develop a plan that identifies the full needs and attempt to convey that to this committee.

Chairman ROCKEFELLER. Under CARES, in a sense, you are looking at the whole spectrum of care so you are going to have to do it internally.

Dr. ROSWELL. I would be happy to do that. I would point out that, without deviating too much, one of the most problematic aspects of the CARES process is being able to, with any kind of reasonable accuracy, project what the veteran population will be at a future year, what the veteran demand for care will be, what the disease burden will be, what health care will be like, and what facilities would be needed to treat that health care burden. It is extremely complex.

Chairman ROCKEFELLER. Do not worry about the future. Your budget may change for some reason. Do not talk to me about the future. Just stop time today and tell me what you would need in order to take today's population and give them the kind of treatment that they fully need.

Dr. ROSWELL. Mr. Chairman, thank you for your continued strong leadership and your advocacy for veterans. We appreciate the guidance you have given us and I will do everything I can to give you that information as quickly as possible.

Chairman ROCKEFELLER. OK, and I thank all of you very, very much for your patience.

Dr. LOSONCZY. Thank you.

Chairman ROCKEFELLER. I will be sending along a few more questions, too.

The second panel consists of Ralph Ibson from the National Mental Health Association; Dr. Renato Alarcón representing the American Psychiatric Association; Colleen Evans, a psychiatric nurse from Pittsburgh's VAMC, representing the American Federation of Government Employees, and two representatives from the National Alliance for the Mentally Ill, Dr. Frederick Frese and Moe Armstrong.

I thank you all for coming. Dr. Ibson, we will begin with you.

**STATEMENT OF RALPH IBSON, VICE PRESIDENT FOR GOVERNMENT AFFAIRS, NATIONAL MENTAL HEALTH ASSOCIATION**

Mr. IBSON. Thank you, Mr. Chairman. I am honored to appear before you today on behalf of the National Mental Health Association and our 340 State and local affiliates. Mr. Chairman, we applaud your commitment, your steadfast efforts on behalf of veterans with mental illness and substance abuse disorders. We are delighted that you have called this hearing.

As has already been said this morning, the VA has a special obligation to veterans with mental illness and substance abuse disorders, an obligation that has been expressly set forth in statute, reaffirmed twice since then. We agree with the findings of the Committee on Care of Veterans with Serious Mental Illness, the so-called "SMI committee." The VA has failed, tragically failed these veterans, breaching both a statutory obligation and what we see as a moral obligation.

People occasionally ask and have asked over the years, why does our government operate a health care system for veterans? They go on to ask, why not meet that obligation through a voucher system or some similar arrangement? For the almost 30 years that I have worked in veteran' affairs, an answer to that question has almost consistently addressed itself to the specialized treatment programs for which VA has long been noted and those programs for veterans with mental illness high among them.

Those explaining the need for the VA health care system have also underscored VA's important role as a safety net. That safety net mission is particularly important and highlighted, I think, for the many members of this committee who have worked so hard and are working so hard for the enactment of mental health parity legislation.

As you know, Mr. Chairman, and others know so well, we have serious problems in the Medicare program and in health insurance with arbitrary limits which discriminate against people with mental illness. Those barriers, in our view, contribute substantially to the reliance that veterans with mental illness place on the VA.

As has been alluded to this morning, some 6 years ago, the VA began a dramatic transformation of its health care system. This committee and its House counterpart foresaw within VA's vision of a decentralized, deinstitutionalized system the potential dangers that came with that move, the potential for unleashing cost-cutting zeal. And you predicted that without safeguards, VA's plans could ultimately threaten the viability of the very costly specialized programs which we have talked about this morning. In essence, you foresaw that without proper checks, the VA health care system could well become a mirror of national HMO plans in the private sector.

The concerns led Congress to the enactment of the special capacity law, which has been discussed this morning. Despite the clear direction in that law, and again, echoing the findings of the "SMI committee," the VA has failed to comply, in our view, with the mandate to maintain program capacity to treat veterans with mental illness and substance abuse disorders.

As the SMI committee has also noted and has been discussed this morning, VA officials beginning in 1998 allowed a policy goal, namely to bring more veterans into the system, to thwart the "maintain capacity" mandate. Department officials queried about this have spoken of the maintain capacity requirement as a, quote-unquote, "unfunded mandate."

In P.L. 104-262, in which the special capacity law was established, Congress, as you know, also established an enrollment system, a system of priorities, with highest priorities to service-connected veterans and the lowest priority for enrollment to veterans who have no special eligibility and whose income exceeds VA's means test threshold. The law makes it clear that those higher-income veterans, as dearly as we hold our commitment to veterans, are only eligible for care "to the extent resources and facilities are available."

The law could not be clearer in instructing VA. Yet in 1998, it did, in fact, open its doors wide, indeed, marketing its health care system to all veterans. The result, as the special committee and others have noted, is more than evident. We have gone from a system dedicated to serving principally service-connected and low-income veterans, which in 1996 had 3 percent of its users as those Priority 7 veterans to a system which next year, according to VA's budget, will enroll one-third of its veterans in that lowest-priority category.

At the same time, as VA mental health and substance abuse programs have contracted and shrunk across the system, having fallen prey to other priorities, the savings from those contractions have been channeled into non-mental health care. In our view, Mr. Chairman, we have to judge the VA system not only by the general quality of care indices which this committee has emphasized, importantly so, but by the quality of its commitment to veterans with mental illness and substance abuse disorders. As a society, we have seen the tragedies of de-institutionalization of our public mental health system as it failed to reinvest dollars into community mental health care, and I am afraid we are seeing the same in the VA today.

Chairman ROCKEFELLER. You will need to finish up.

Mr. IBSON. I shall.

I think it is important for the committee to turn to stronger measures than the capacity law which was an important step, but one which has not borne the fruit we hoped. I would urge the committee to continue its vigorous oversight efforts which have made an important difference, and to look to steps like "fencing" funding, which VA has done successfully in the past, as a way to ensure that its mental health commitment is made and made effectively.

Chairman ROCKEFELLER. I will have a question about that later.

Mr. IBSON. Surely.

Chairman ROCKEFELLER. Thank you very much.

[The prepared statement of Mr. Ibson follows:]

PREPARED STATEMENT OF RALPH IBSON, VICE PRESIDENT FOR GOVERNMENT AFFAIRS,  
NATIONAL MENTAL HEALTH ASSOCIATION

Mr. Chairman and Members of the Committee:

I am honored to appear before you today on behalf of the National Mental Health Association (NMHA). My testimony will draw in part on my work as a member of the staff of the House Veterans Affairs Committee from 1990 to 2000.

THE NATIONAL MENTAL HEALTH ASSOCIATION

NMHA is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. In partnership with our network of 340 state and local Mental Health Association affiliates nationwide, NMHA works to improve policies, understanding, and services for individuals with mental illness and substance use disorders. NMHA sits on the Consumer Liaison Council of the Committee on Care of Veterans with Serious Mental Illness. Mr. Chairman, we applaud your commitment and continued interest in assuring that VA meets its obligations to veterans with mental illness and substance use disorders.

CRITICAL DECLINE IN VA SPECIALIZED MENTAL HEALTH TREATMENT CAPACITY

The VA health care system has a special obligation to veterans with mental illness and substance use disorders. That obligation was expressly set forth in statute in 1996 and reaffirmed with even greater specificity last year in Public Law 107-135. VA also has a profound moral obligation to veterans with mental disorders. Yet it has failed, and continues to fail these veterans, by breaching both its statutory and moral obligations. Those failures are both tragic and inexcusable. But they are all the more shocking when one considers that as VA has diminished its support to veterans who are most vulnerable and most in need of VA assistance, it has virtually altered its mission to serving an ever-growing number of those with the lowest claim to VA care.

THE SIGNIFICANCE OF VA'S SPECIALIZED TREATMENT PROGRAMS

During my years working in the House I was asked from time to time, why does our Government continue to operate a health care system for veterans? Why, some questioned, couldn't the obligation owed veterans be as effectively discharged through a voucher system or some similar arrangement? The response I gave—and VA officials continue to give to such questions—consistently cited VA's specialized treatment programs for veterans with mental illness as a critical core that sets VA health care apart as a vital resource that should be preserved.

VA: A UNIQUE "SAFETY NET" FOR VETERANS WITH MENTAL ILLNESSES

Those explaining the importance of maintaining the VA health care system also cite its unique role as a "safety net" for veterans. That safety net mission is particularly important to veterans with mental illness or substance use disorders because—unlike many other veterans—these individuals often lack other health care options. As the many members of this committee who have fought for mental health parity well know, both the Medicare program and most private health insurance imposes arbitrary, discriminatory barriers to mental health care. Under the Medicare program, individuals face a 50% copayment for outpatient mental health services and a lifetime cap on coverage of psychiatric hospitalization. Most employer-provided health plans have evaded the spirit of the Mental Health Parity Law of 1996 by substituting other discriminatory mechanisms (such as limits on numbers of out-

patient visits or days of hospital coverage, or greater cost-sharing burdens) to limit coverage of mental health services. These barriers contribute substantially to the reliance veterans with mental illness place on VA for care. For example, more than 50 percent of veterans service-connected for a psychosis, and more than 60 percent of veterans service-connected for PTSD, used VA health care services in FY 2000.

#### STATUTORY DIRECTIVE TO MAINTAIN SPECIALIZED PROGRAM CAPACITY

As you know, Mr. Chairman, some six years ago VA embarked on what became a major transformation of its health care system. But this committee and its House counterpart recognized the potential dangers in VA's plans. You foresaw the unleashing of cost-cutting zeal within VA's vision of a more decentralized, deinstitutionalized system. And you predicted that, without adequate safeguards, VA plans could ultimately threaten the viability of often costly specialized treatment programs, including those that served veterans with mental health and substance-use problems. In essence, you foresaw the risk that, without proper checks, VA could unwittingly transform itself into a national HMO with little to distinguish itself from other then existing private-sector systems.

Those concerns led Congress in 1996 to enact statutory language (within an eligibility-reform law) to protect the unique specialized programs that distinguished VA and served those veterans most in need of the system. That law imposed a requirement that VA maintain its then existing specialized treatment capacity to serve veterans with mental illness and other specified conditions. Section 1706(b) of title 38, U.S. Code (amended in P. L. 107-135) expressly directs the Secretary of Veterans Affairs to provide for the specialized treatment and rehabilitative needs of veterans with mental illness and substance use disorders by operating and maintaining distinct programs and facilities dedicated to their specialized needs. The law requires the Secretary to ensure that the overall capacity of the Department to provide those specialized services is not reduced below the capacity VA had in place in October 1996. The law further directs the Secretary to afford veterans who have a mental illness or substance use disorder reasonable access to care for those specialized needs. Despite that direction in law, the VA has failed to comply substantially with the mandate to maintain required capacity to treat veterans with mental illness or substance disorders, as documented by the annual reports of the VA's Committee on Care of Veterans with Serious Mental Illness (hereinafter "the SMI committee"). For example, during a period in which medical care appropriations increased 30 percent, the SMI committee reports that 18 networks showed a decline in inflation-adjusted dollars for the care of veterans with serious mental illness. In substance-use, 20 networks showed a decline, with a 15 percent decline in number of patients overall. Decentralization has aggravated the problem. VA data has consistently showed wide variability from network to network in the services available to veterans with mental health needs.

#### VA POLICY AND STATUTORY DIRECTIVES CONFLICT

Largely ignoring the "maintain capacity" mandate, VA officials over the years allowed their own policy goal—to bring more veterans into the system—to thwart this statutory directive. The Department has since sought to explain away its obligations to veterans with mental illness as "an unfunded mandate."

In Public Law 104-262, which required VA to safeguard its specialized treatment programs, Congress also directed VA to institute an enrollment system to govern access to VA health care. Enrollment is to be managed to ensure that VA care is timely and acceptable in quality. Under this system, eligibility to enroll for VA care is to be based on statutory priorities. Service-connected veterans have highest priority, veterans who are deemed financially needy have a lower standing, and those who have no special eligibility but have income exceeding VA's means-test threshold have the lowest priority for care. The law makes clear that those with the lowest-priority-for-enrollment (often referred to as "priority 7" or "category C" veterans) are eligible for care only "to the extent resources and facilities are available." (38 U.S.C. section 1710(a)(3)). The law could not be clearer in instructing VA that it may not open its doors to these higher-income veterans unless it has the resources to do so. In implementing the 1996 law, however, VA officials ignored the statutory directive to assure that the needs of those with the highest priorities could be met, and opened VA's doors wide. In fact, in many areas VA marketed its health care services to all veterans.

The results are not surprising. In 1996, when Public Law 104-262 was enacted, "priority 7" (high-income) veterans made up approximately three percent of those who used the VA health care system. VA's budget submission this year discloses for the first time that "priority 7 veterans" will make up one-third of VA enrollees in

2003. The SMI committee puts the issue in stark perspective in its most recent report. The committee highlights the skyrocketing growth in VA dollars (nearly \$1 billion in FY 2001) devoted to those—like myself—who have the lowest priority for services and often have other health coverage. At the same time, VA mental health and substance abuse programs, which overwhelmingly serve service-connected and low-income veterans, have fallen prey to sweeping contraction and cost-cutting in many parts of the country. Rather than channeling those savings into new programs for veterans with mental health and substance use needs, VA has allowed a redirection of those funds to non-mental health care—in clear violation of the capacity law. Using those funds, VA has successfully attracted new “priority 7 veterans” each year into a growing base of system-users. These higher-income veterans frequently also have coverage through Medicare or employer-provided health insurance. While more veterans use VA care than did in 1996, the percentage who receive any type of VA mental health service—in a system demonstrably less able to serve them than it was in 1996—has declined.

What is being lost in this extraordinary transformation is both VA’s ability to deliver needed services to those most in need of assistance, AND something of the very legitimacy of this health care system.

Since it enacted the requirement to “maintain capacity”, Congress has twice amended that law. To date, however, it is not apparent that VA has moved substantially toward compliance. In fact, following the enactment of Public Law 107–135, which clearly requires VA to expand mental health and substance use programs to restore lost capacity, VA’s budget submission for Fiscal Year 2003 fails even to mention this law.

#### FUTURE DIRECTION

Mr. Chairman, this is an important hearing that I believe can help the Committee reach some important decisions on the future direction of VA mental health care.

We must judge the VA health care system not only by general quality-of-care indices, but by the quality of its commitment to those grappling with mental illness. As a society we have seen the tragedies that have come about because dollars freed up from deinstitutionalization in our mental health system were not reinvested into community mental health care. Will we repeat that mistake in the VA health care system? To date, we have. Through leadership in the U.S. Senate, we are moving toward mental health parity in the private sector. Should we require less of the VA? If not, we should examine the manner in which VA allocates funds. Contrast the high-tech services in its medical and surgical suites with the relatively limited funding dedicated to mental health care and substance use needs at many VA facilities. We are very far from anything approaching parity. Indeed VA has yet to attain the more modest goal of maintaining the level of service provided six years ago.

Permit me to offer just two more examples that raise questions about the Department’s commitment to veterans with mental illness:

- The VA has for years operated rehabilitation programs that emphasize work-therapy to assist people to normalize their lives as part of a recovery process. VA’s Compensated Work Therapy (CWT) Program, in particular, aims to foster rehabilitation and re-entry into the community by providing opportunity for learning social and work skills, earning money and gaining the self-respect that comes from employment. In Fiscal Year 2000, of those discharged from CWT, 46 percent were placed in competitive employment and another 8 percent were placed in training programs. Despite successes this program has demonstrated, a comprehensive program evaluation conducted last year by VA’s Serious Mental Illness Treatment Research and Evaluation Center (SMITREC) highlights that VA has failed to insure that veterans with serious mental illness participate in CWT. SMITREC found substantial underutilization of the program by such veterans who are in their prime working years and shown to be employable with appropriate supports. While current research shows that most people with severe, chronic mental illness want to work, less than 1 percent of the 82,000 veterans with psychosis age 50 or less participate in VA CWT.

- The General Accounting Office (GAO) completed a study this spring examining VA’s prescribing guideline for atypical antipsychotic use to determine whether it has restricted access to medications and adversely affected the quality of mental health services provided to veterans. GAO found that nearly one in ten VA psychiatrists responding to its survey reported they did not feel free to prescribe the antipsychotic drug of their choice, and numerous VA facilities have implemented procedures that “have limited or could restrict access to certain atypical antipsychotic drugs on the VA’s national formulary because of cost considerations.” Given that some 50 percent of veterans treated by VA for schizophrenia are service-connected for that illness,

with more than 130 thousand veterans service-connected for psychoses, we question whether VA would permit cost to be a consideration, let alone a determining factor, in treatment decisions regarding any other group of service-connected veterans.

#### RECOMMENDATIONS

NMHA would be pleased to offer recommendations on the two issues cited above. But the record of the last six years certainly suggest that strong measures are needed to realize the goals of the "maintain capacity" law and the special obligation owed veterans with mental illness and substance use disorders. In our view, an appropriate response must take account of both the highly variable commitment among VA's 21 networks to mental health and substance use services and the erosion that has occurred systemwide. This Committee has been more than patient. Additional legislative efforts which result, at best, in directives from a Central Office that fails to enforce its policies do not appear to offer promise. NMHA would urge the Committee instead to consider more "invasive surgery" to include requiring VA and its networks to "fence" (that is, segregate and track) funding for mental health and substance use services, with meaningful penalties for diverting those funds to other uses. Prior to 1996, "fenced funding" did offer protection to vulnerable mental health programs while three rounds of legislation clearly have not. Ultimately, however, such efforts must be combined with the kind of aggressive oversight this Committee has long exercised, and for which we thank you, Mr. Chairman.

This concludes my statement. I will be happy to answer any questions the Committee may have.

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#### RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO RALPH IBSON

*Question 1.* Your testimony stated that Congress should require VA to "fence" monies allocated for mental health so as to be absolutely sure that it is spent on mental health. Why is the Congressional mandate to maintain capacity not enough? Why is it necessary to make such a change?

*Answer.* The testimony presented at this hearing (and the record of earlier hearings) underscores that the "capacity law" has not adequately protected the fragile VA infrastructure that served veterans with mental illness and substance use disorders, and, did not provide an effective check or constraint on administrators operating in a decentralized health care system who were more responsive to fiscal and other pressures than to a statutory policy. While the capacity law sets an important "line in the sand" its intended beneficiaries—veterans with mental illness and substance use disorder—have lost ground and suffered because of the difficulties inherent in enforcing its mandate, particularly in a decentralized system. The continued fiscal pressures facing the VA health care system will further test the "capacity law". But short of providing Congress with data to document continued shortcomings, the law itself provides no assurance that Department officials—making allocation decisions in 21 different networks and among hundreds of VA facilities—will jointly and individually dedicate the funds needed to realize the requirements of the law. Employing a mechanism such as "fenced funding", provides a tested, credible "audit-able" means of ensuring that funds appropriated and allocated for mental health and substance use disorder care are in fact channeled to those purposes and are not siphoned off to other purposes.

*Question 2.* Some inpatient mental health beds will always be necessary. In VA, however, there is a tremendous propensity to cut these kinds of beds. How can VA find the right balance?

*Answer.* Experience has shown us that with proper treatment and support services, people with the most severe mental illnesses can live successfully in the community, and at lower cost than keeping them in inpatient care. There are model programs, such as The Village Integrated Services Agency in Los Angeles, that VA could look to for guidance. If appropriate community services were in place, it is likely that only a very small percentage of veterans with mental illness would require long-term hospital care. Until VA puts adequate community services in place, we unfortunately won't really know how many veterans truly need long-term inpatient care.

The problem with "cutting beds," however, is that these funds have not followed the veteran into the community. (The fact that many VA outpatient clinics don't even have mental health personnel, let alone provide more extensive treatment or support services is very disturbing.) Funding for even one patient bed should never simply be "cut"—if bed closures are warranted, funding should be always be "transferred" to the array of services needed to support the individual in the community,

and that individual must have a detailed treatment plan with guaranteed access to those services prior to discharge.

Certainly we should avoid a situation where the only choices available to a veteran with severe and persistent mental illness is institutionalization or discharge to a community without adequate service systems. With that stark choice, no "balanced" solution exists. VA must develop community mental health services that will minimize the number of inpatient beds needed.

Chairman ROCKEFELLER. Dr. Alarcón?

**STATEMENT OF RENATO D. ALARCON, M.D., PROFESSOR OF PSYCHIATRY, EMORY UNIVERSITY, REPRESENTING THE AMERICAN PSYCHIATRIC ASSOCIATION**

Dr. ALARCÓN. Mr. Chairman, I am a psychiatrist and currently a Professor of Psychiatry at Emory University School of Medicine in Atlanta, and until March 20, 2002, Chief of the Mental Health Service Line of the Atlanta VA Medical Center, where I work for a total of 9 years.

As a member of the American Psychiatric Association since 1970, I am honored to represent in this hearing, dealing with very crucial aspects of the delivery of mental health care in such a large and unique system as the VHA.

I thank you for the opportunity and request that my full written testimony be included in the record.

Chairman ROCKEFELLER. Doctor, all testimony is fully included, so you need to sort of get to the basics.

Dr. ALARCÓN. The shortest answer to the central question of this hearing, Mental Health Care: Can the VA System Still Deliver? Is, yes, it can, but it does not do it now.

My testimony will address five areas to substantiate this assertion: financial, clinical, logistic, research, and what I call dynamic or environmental interactions between different components or members of the system.

On the financial front it has been said many times it will never be enough. The budget allocation for mental health care within the VA is still short of what is really needed. A number of figures have been presented. I am now going to insist on that. The APA recommends the allocation of more financial resources for mental health in the VHA compatible with the growing, clinical, academic, administrative and research needs of the system and its specialized programs. Furthermore, budget resources should restore depleted services in some programs and reflect a fair revenue distribution based on workload served and complexity of cases cared for.

Chairman ROCKEFELLER. Doctor, can I interrupt and ask how the American Psychiatric Association has pushed on the subject of more resources? Are you simply saying that in testimony today, or has there been an effort by the Association to affect budget levels in this committee or with the administration?

Dr. ALARCÓN. It is a consistent policy and actions on the side of the American Psychiatric Association to request, support and push for these type of requests.

Chairman ROCKEFELLER. Obviously, there is a constant desire to see it happen, but it sort—when did you last call up OMB or last call up Dr. Roswell, or last had all of your folks write? In other words, how do you put on pressure?

Dr. ALARCÓN. The VA caucus in the APA is very active. Less than 2 months ago the APA was one of the signatories of a letter to Mr. Principi, and has continuously requested this type of action. In April, APA testified before the House VA Appropriations Committee and in March met with Senate staff. The context between the leaders of the American Psychiatric Association, Congress Committees and the VA are frequent members, M.D. members of the VA are members of the American Psychiatric Association, and they channel their views through the existing caucuses and committees.

Chairman ROCKEFELLER. I'm going to push that more. You may remember that the American Psychiatric Association, for year and years fought psychologists from them getting reimbursed under Medicare. In the end, psychologists receive reimbursement under Medicare. Now, that is just the historical benchmark for asking. Do you work alone as psychiatrists or do you work with others who care about mental health care, and specifically, do you team up with psychologists and others in your lobbying effort to get the resources for what you want ?

Dr. ALARCÓN. I think you are touching on one aspect of what I was going to talk about which is the dynamic aspects of the works of the VA system and professionals within the VA system and psychiatrists and psychologists specifically. I think that regardless of discrepancies between professions, leaders and the work force in those professions understand that the cause of the veterans is extremely important. I have been aware of how the multi-disciplinary effort, which by the way, has been best represented in medicine by psychiatry, goes beyond the boundaries of the medical profession, and requires us, it has been said many times, the multi-disciplinary effort. It is in that context that the actions in favor of veterans have been, I would say, united. It has been a united front and the American Psychiatric Association, regardless of inter-professional politics I think has the highest cause of the veterans in sight.

Chairman ROCKEFELLER. Thank you, and I apologize for interrupting you.

Dr. ALARCÓN. Can I continue?

Chairman ROCKEFELLER. Oh, yes.

Dr. ALARCÓN. Thank you very much.

It has been also said that from the clinical perspective, mental health parity in practice does not exist in the VA. The example of substance abuse programs is more than eloquent, and it has been discussed here. I want just to say that together with implementation of a mandate for the prompt establishment of opioid substitution programs or methadone clinics, the APA supports and requests the immediate inclusion of mental health services in more than half of the existing community based outpatient clinics, the CBOC's, that still do not have them, and the strengthening of mental health intensive case management, homelessness, post traumatic stress disorder and compensated work therapy programs. Furthermore, resources for psychotropic medications should be protected and this has been discussed already.

Logistically, I want to emphasize again the need for a full compliance with a capacity low, and the continuous close supervision of its implementation by individuals and groups working in the

field. To give budget and more significant administrative responsibilities to clinicians, rather than limiting them to the hands of known clinicians would be wise. Furthermore, the shortage of psychiatrists and other mental health professionals that compromises the quality of services provided must be squarely addressed.

In the research arena less than 9 percent of the VA health research is dedicated to mental illness and substance abuse issues, even though 35 to 40 percent of the VA patients need mental health care. We respectfully request and support that three additional MIRECC's be funded in fiscal year 2003. The need to develop a strategic vision for the further development of mental health research in the VHA is pressing. More collaboration with funding agencies such as the NIMH and with those of affiliated economic centers must be pursued.

Finally, let me examine two clusters of dynamic issues within the system. The first is the relationship between administrators and clinicians. It is no secret that there is a sort of warfare between these two groups. Many administrators give preference to those considered more powerful clinical players. And I must say with all due respect to my colleagues in medicine, primary care, surgery, et cetera that mental health deserves better in the system. Some administrators may be passive instruments of an overall stigmatizing environment. Prejudice against the mentally ill is still a powerful factor in some segments of the VHA staff. The same ambivalence is reflected in the way administrators deal with the relatives of mentally ill patients. This mentality may be more or less subtly rationalized by the enthusiastic embracing of business like practices imported from the managed care sector. APA strongly recommends multi-disciplinary and interprofessional activities for administrators and clinicians, aimed at a continuous awareness of the social, cultural and human uniqueness of the veterans with mental illness.

The second dynamic issue has to do with the relationship—

Chairman ROCKEFELLER. You will need to finish up.

Dr. ALARCÓN. I appreciate that—between VA medical centers and their academic affiliates.

I just want to say that the healthy tension between the VA and the academic affiliated institutions' agendas can only be healthy if it is a balanced interaction between and a truly integrated work among the components.

In summary, Mr. Chairman, there is no mental health parity in the delivery of care to VHA system. A great variety of indicators establish clearly the increasing numbers of patients, the systematic decrease in resources and a pervasive sense of a stigmatization of veterans with mental illness. Mental health is still treated as a Cinderella, a younger sibling, a relegated component of a historically important system. While a lot of progress has been made, much remains to be done before a profound respect for the human dignity of psychiatric patients and their families must help to open a path of hope for them, a path always worth walking.

Thank you very much.

[The prepared statement of Dr. Alarcón follows:]

PREPARED STATEMENT OF RENATO D. ALARCÓN, M.D., M.P.H. AND THE AMERICAN  
PSYCHIATRIC ASSOCIATION

Mr. Chairman and Members of the Committee:

My name is Renato Alarcón. I am a psychiatrist, currently a Professor of Psychiatry at Emory University School of Medicine in Atlanta, and until March 20, 2002, Chief of the Mental Health Service Line, at the Atlanta VA Medical Center where I worked for a total of nine years. I am honored to participate in this hearing on behalf of the American Psychiatric Association. I was born in Peru, I am an American citizen, graduated as M.D. in my native country, did my residency training in the United States, and have been mostly a clinician, medical educator, and academician throughout the almost 30 years of my professional career. The last nine years have clearly enriched my experience also as an administrator, and it is in all of these capacities that I attend this hearing whose central topic touches on very crucial aspects of the mental health care delivery in such a large and unique system as the VHA.

My opinions are those of one who has learned to appreciate the extraordinary role that the VHA plays in the care of individuals who served their country loyally and devotedly, and who of course deserve the best care they can be provided. At the same time, my opinions also are as objective as I can be in trying to emphasize both the positive and negative elements in the structure and operations of such a complex system. I am guided by the American Psychiatric Association's commitment and my own desire to contribute to the national debate on health and mental health issues, critical for the present and the future of our nation.

From the more than 15 million veterans in this country, conservative estimates indicate that more than 25% have some kind of mental problem. Out of more than 4 million individuals who received health care in the VHA system in 2001, 712,045 (almost 20%) required mental health care, an increase of 44%, from the 494,386 seen in 1990. There is, however, significant consensus in that we are seeing only a small number of those in need, another example of the proverbial "tip of the iceberg." Furthermore, veterans with mental illness have significant medical comorbidities, that is coexisting medical conditions, that make their care even more complicated. Even worse, the majority of mentally ill veterans experience problems in their social, family, and community interactions—between 45 and 65 % of the homeless population in this country are veterans with mental conditions. Their lives have been further devastated by the concomitant use or abuse of alcohol and drugs, consumed in many cases as desperate attempts at self-treatment of their underlying emotional condition. These social circumstances make them also a rather mobile population, unsettled both emotionally and geographically, mistrustful of a system that they perceive with significant ambivalence, and voiceless in the face of their own handicaps when dealing with sources of funding, legislation, and society's support.

The testimony will examine five areas of mental health care in the VA system, trying to utilize existing hard data as well as, whenever possible, my personal experiences throughout the last 9 years. The areas are: Financial (budget issues), Clinical (programs), Logistic (personnel, structural, and administrative), Research, and last but not least, a series of what I would call "Dynamic" or environmental interactions between different components of the system that provide a somewhat hidden but enormously impacting background for the everyday operations of mental health care in the VHA.

#### FINANCIAL ASPECTS

**Budget allocations.** It has been said many times but it will never be enough: The budget that the VA provides for mental health care is still short of what is really needed. The total per capita expenditures for veteran mental health patients has declined by 20.6% since 1995. Between 1995 and 2001, the number of veterans in need of mental health services has increased 26%, yet the total mental health expenditures have increased only 9%.

While I personally am of the opinion that money does not solve every problem, it is clear that in some areas of mental health care in the VHA, more financial resources are needed. As is well known, the Veterans Equitable Resource Allocation (VERA) program was established as a way to connect volume of services and workload with income for Networks and, through them, to local facilities. While the VERA model has evolved on the basis of recognizing previous limitations and difficulties, and recommendations have been recently made by the VERA Patient Classification Workgroup on Mental Illness regarding development of new complex care classes, qualifications for assistance, and the number of days needed for long term psychiatric care, VHA must do more to ensure that there are no financial disincen-

tives, and to correct VERA's skewed dimensions that hurt the care of special populations. The SCMI suggested that VERA be assessed and revised to assure that the overall cost of mental health cohorts is in alignment with and not greater than the overall VERA revenue distribution to those cohorts. In fact, GAO has recommended, as recently as the past February that VA better align VERA measures of workload with actual workload served regardless of the veteran priority group, incorporate more categories into VERA's case mix adjustment, update VERA's case mix weights using the best available clinical data on clinical appropriateness and efficiency, determine what has caused budget shortfalls in the Networks, and establish a mechanism using the national reserve fund to partially offset the cost of the highest complex care patients. A forthcoming Rand Corporation study will hopefully further these requests.

**Budget management.** It is well known that some Network directors and other administrators such as Medical Center Directors claim to favor the inclusion of mental health services in CBOCs but question how to fund such services, and whether all CBOC's should provide mental health services. This view does not make sense. Similarly, programs such as SA (Substance Abuse) and PTSD (Posttraumatic Stress Disorder) should have depleted services restored. On the other hand, even though a recent memorandum recommends that contract orders be rolled into the grant-per-diem program in order to make dollars available to new Homeless Veterans programs, and thus insure their survival, and that this grant-per-diem program may be an effective vehicle for maintaining capacity in SA abuse programs, the sheer fact is that there has been an erosion of access to these specialized services in the VHA since 1996. Network and local facility leaderships continue to ignore management directives and Congressional mandates in this regard, and they need to be held accountable.

The Millennium Bill mandated that in FY 2000 VHA increase funding for SA and PTSD by at least 15 million dollars on an annual basis. In June 2002, the Under Secretary agreed that requests for proposals (RFPs) should be issued, and that off the top funding should be provided for the period of time necessary to assure that the programs are deployed, mature, and generate sufficient VERA funds (which have a lag time of two years) to assure their continued financial viability. The RFPs and the distribution of funds were delayed. Many programs were either not deployed in fiscal year 2001 or were deployed late in the year. The SCMI has recommended that special purpose funding be supplied to these programs in both FYs 2002 and 2003. The Under Secretary has concurred that whenever possible, specialized programs should be maintained beyond the 2-year minimum to meet the intent of the law. That is certainly our position.

#### CLINICAL ASPECTS

The inequities towards those with mental illness that one sees in other health sectors in the country, also persist in the VA system. Mental health parity, in practice, does not exist in the VA. Some of the most significant examples follow:

**Substance Abuse.** Substance Abuse (SA) is a dramatic example. While total VA spending rose 10% between 1993 and 1999, spending for SA treatment declined by 41%, from almost \$ 600 M to about \$ 330 M in the same period. The number of VA SA treatment programs decreased by 37% between 1994 and 2000, from 386 to 243. In 1996, only 33 % of patients diagnosed with a substance abuse disorder received specialized care. From 1996 to 2001, the number of severely mentally ill (SMI) patients treated for SA decreased by 15,935, an impressive 15%. The proportion of VA SA programs that have veterans waiting for treatment is rising: between 1994 and 2000, 68 to 75% in inpatient settings, 58 to 80% in residential, 42 to 60% in intensive outpatient, and 41 to 51% in standard outpatient settings.

More recently, the establishment of Opioid Substitution Programs or Methadone Clinics, mandated for the system in response to a real need among veterans, and in order to correct the ill consequences of a massive bed closing executed about seven years ago, has not been implemented in a number of Networks. (Incidentally, the number of beds in SA inpatient and residential treatment settings was 5,920 in 1994, and only 2,893 in 2000). Reasons invoked for the slowness of this implementation range from the fact that the money devoted to this program has not been "fenced", to the feared prospect that in three years, local facilities or Networks will have to assume the expenses related to these programs. The result is that more than half of the Networks have not yet established Methadone Clinics, particularly in metropolitan areas where patients in need concentrate sometimes in dramatic numbers.

**Community-Based Outpatient Clinics (CBOCs).** The medical care of the mentally ill veteran is a truly critical area. Psychiatric patients (particularly among vet-

erans) do have a significant number of medical complications, larger than the non-psychiatric patients. In this context, the connection between mental health and primary care services is critical for a better, more efficient and effective care. The primary care programs, justifiably so, receive significant support from the VHA, and the establishment of the Community-Based Outpatient Clinics (CBOCs) a little over two years ago was deservedly applauded. That has not built up, however, the strength of comprehensiveness in the case of mental health care, as reflected on the fact that only 47% (265 out of 561) of the Networks that have CBOCs do include some mental health services, and that almost 20% of them provide very few service options.

The CBOC mandate, that confirms the theoretically valid and necessary visibility of mental health in the outreach clinics, has little to show at the present time. This reality is devastating because mental health is not going to be addressed appropriately in close physical connection (location wise) with medical clinics, the most ideal approach. Again, it's a case of foot-dragging by administrators who in the name of "savings" may not hesitate to sacrifice mental health, first and foremost. They make promises, they can even say that they are impressed by the commitment of mental health clinicians to develop these programs (which, by the way, are a good example of the correct approach to bed closing) but then do nothing to implement them. The problem gets worse because of the aging of the veteran population. The CBOCs are expression of the best intentions to outreach veterans in areas where hospitals cannot have an impact; they also sanction the value of interdisciplinary care, but the VA is letting us all down by providing more support to the development of these programs in other departments, Primary Care in particular. In this context, Congress should be, as it has always been, an effective ally of the mental health community in the VA.

**Mental Health Intensive Case Management (MHICM) program.** Other VA programs also suffer. The Mental Health Intensive Case Management (MHICM) program, a well proven alternative to hospitalization based on a close and comprehensive approach to care, saves money but lacks in resources, and therefore reaches only a minimal portion of patients in need. In October 2000, the VA identified 9538 MHICM eligible veterans (based on the number of patients discharged from inpatient psychiatric beds), and yet as of March 2002, there were only 3298 MHICM slots available. Some modifications in the criteria to include patients into the MHICM program could enlarge the population to be served. Psychiatry and mental health have advanced in the conceptualization and operation of therapeutic programs such as MHICM, and the crucial question is whether we as a society are ready to dedicate the funding to sustain them.

**Homelessness and Posttraumatic Stress Disorder (PTSD) programs.** These programs have been paid attention by the VHA, Congress, the government and other sectors. Nevertheless, the fact is that for specialized intensive PTSD treatment programs, the average waiting list time is 47.15 days, and at some facilities veterans must wait as long as one year for an intake diagnostic assessment. PTSD patients considered as severely mentally ill (SMI) increased 42% from 1996 to 2001, while expenditures increased only 22% during the same period. Veterans who are service-connected for PTSD use VA mental health and medical services at a rate at least 50% higher than other user groups.

**Compensated Work Therapy (CWT) program.** The access to newer treatment modalities (cognitive behavioral therapy, intensive psychosocial rehabilitation, etc.) requires funding. Only 30,000 of the 678,000 veterans served in the VA mental health programs received any form of work-based rehabilitation in 2001 (80,000 of them are under the age of 50). The unemployment rate for people with mental illness is approximately 75%. In 2001, 67% of veterans in specialized outpatient PTSD programs were not employed. Less than 1% of the 82,000 veterans with psychoses age 50 or less participate in the VA's Compensated Work Therapy (CWT) program, an initiative worthy of more consistent support that, for instance in my Medical Center, was specifically targeted for "savings".

To summarize, the numbers of individuals assisted by these programs are still relatively small, the complexity of their clinical realities is not addressed comprehensively, the resources are not there, and administrators are reluctant to provide them with minimal technical equipment. Appropriate screening teams and programs among homeless, the issue of comorbidity and multiple diagnoses among PTSD patients, the social and employment (or lack thereof) sequelae of these conditions are realities that the system still needs to face squarely. The VHA has issued a wonderful set of practice guidelines for depression, psychosis, substance abuse, plus one for PTSD coming soon. It is fair to say, however, that in spite of well written technical, clinical, and professional norms, the implementation of programs has to do as much

with financial resources as it does with disposition, interest, and sincere commitment to the cause of the mentally ill veteran.

**Pharmacy and medication resources.** The issue of pharmacy resources and medication availability for mental illness is also an important one. There have been reports (including one by the GAO) that some Networks have established either rigid limits for the use of some medications (for instance, atypical antipsychotics), or have simply insisted on the use of old medications or of generics, together with other restrictions. I am not talking about a universal phenomenon, but we all know that even a few cases can “make or break” a policy and the programs that it intended to inspire. While it is true that resources for pharmacy need to increase in general (due to a number of decisions made regarding treatment of some chronic medical conditions), the fact that money devoted to psychiatric medication agents is diverted to those other areas comes very close to being short-changed, and to think that our patients may not be considered as “important” as medical patients. Is there a difference between the suffering that shortness of breath brings to a patient and that of those who are hearing voices, are devastated by anxiety or depression, are contemplating suicide, or wander around in the city or under the bridges? The budget for psychotropic agents, and not only generics, should be increased and protected to keep its intended purpose.

#### LOGISTIC ASPECTS

**Capacity.** The capacity of any given health care system (in simple terms, the number of individuals being served and the resources with which the system counts) is a crucial logistic concept. The Congress approved the Capacity Law (38 U.S. Code, Section 1706 (b)), and established several years ago, the Severely Chronically Mentally Ill (SCMI) Committee, currently named Committee on Care of Veterans with Serious Mental Illness, to primarily monitor the ongoing measures of capacity related to the care of the mentally ill veteran. This Committee has been a driving force in protecting the rights of mentally ill veterans, and calling the attention of the Department of Veterans Affairs and the VHA in dealing with their plight. The sad reality is that in the last 6 years (between 1995 and 2001), the number of veterans in need of mental health care has increased 26%, the cost has been reduced about 4% for programs and 24% for patients, the average length of stay in inpatient units has been reduced almost 42%, and yet (as mentioned above) the mental health care expenditures have increased only 9%. The conclusion is clear. The VA is not providing the same number and perhaps even quality of service to mentally ill veterans, in spite of efforts and declarations in that direction. Moreover, each time these incongruities have been called to the attention of the system, the bureaucracy has rallied around the cry of “capacity is being maintained”. That is simply not true.

**Managed Care “imports” and Quality of Care.** Some time ago, there was a not-so-subtle pressure to reduce significantly the average patient stay in the inpatient units. Like many others, these parameters were copied or “imported” into the VA from the Managed Care sector. The specific suggestion was to reach an average inpatient Length of Stay (LOS) of 5 or 6 days, while before 1993 such stay was 35 or more days. In my Service we made a determined effort to reduce the stay but with two provisos: one, to be able to establish adequate continuity of care and follow up in the outpatient clinic or our community psychiatry programs, and two, not to go down to the 5 suggested LOS days; rather, we determined that nine or ten days was the minimum acceptable for a decent (not necessarily the best) care of a veteran with mental problems. We have to continuously remind the administrators that the mentally ill veteran is not the average middle class “healthy neurotic” that may be seen in the private sector, or even in some community mental health centers.

The administrators’ emphasis on “productivity” and “efficiency” run a collision course with quality. I think this only reflects an excessive business-oriented philosophy that can have unintended consequences, such as a saturation of available services caused by opening the door to individuals for whom the VA is not necessarily a “safety net”. We, clinicians, are understandably mostly interested in quality of care. This is part of the humanistic dimension of medical care in general, and mental health care in particular, where many emotional, subjective, and human aspects of existence are threatened. I am afraid this dimension is being lost in an atmosphere colored by managed care practices and cold, some times callous managerial decisions. I have observed that whenever there are financial difficulties in a Medical Center, mental health is one of the first services to be looked at, and eventually cut out of resources. On the other hand, whenever a fiscal bonanza occurs, mental health is the last one to get resources. This, no matter how loudly the Mental Health Service Line representatives speak about the issues. This may be a case of what we call “selective inattention”. And I wonder if all these factors help to under-

stand why the overall satisfaction with inpatient mental health care, for instance, has declined 15% since 1995.

**Workforce shortages.** There is a shortage of physicians and other mental health professionals in the VA workforce. It is not a secret that whenever a vacancy occurs in a psychiatrist position, administrators immediately start thinking about either eliminating such position, or recruiting a non-psychiatrist professional to replace him/her. This goes against technical criteria, professional rules, and even the interdisciplinary atmosphere that needs to operate in environments like mental health care. Nobody is suggesting that every leadership position should be occupied by psychiatrists, but it is important to recognize levels of expertise, training, clinical experience, and background to consider these possibilities. Furthermore, salary schedules need to be revised in order to make VA positions more attractive. It is true that a number of International Medical Graduates (IMGs), and perhaps even minority American Medical Graduates (AMG) physicians compose a significant segment of the VA workforce in mental health. That is a very relevant and not frequently acknowledged or fairly analyzed contribution of minorities and IMGs to the viability of the system. It is important to make sure that Continuing Medical Education (CME) and other professional opportunities for advancement are always available. The personnel problem in clinical areas of the VHA system (and mental health is not an exception) has become even worse when we consider that nursing staff, for instance, is currently at its lowest level ever. The quality of services is, thus, doubly compromised.

**Performance evaluation.** The DVA adopted in recent years the mechanism of issuing a "report card" outlining the performance of individual networks, and even individual facilities. While the purpose is good, the data included may be misguided since it provides more relevance and weight to administrative views or data rather than clear clinical indicators. In this connection, the overall clinical and operational functioning of Service Lines in the system, at the local facility level, is the subject of a study by Dr. Robert Rosenheck and collaborators, to be published soon in a prestigious medical journal. These authors measured continuity and quality of care over a 6-year period before and after the 1995-1996 reorganization, in 139 VA Medical Centers. The assumption that the first year of the establishment of Service Lines (SLs) would be worse, with gradual improvement over the years, along the lines of six indicators utilized by the study, did not pan out. In fact, the results indicated that the first year after the establishment of SLs was better than the second year, when no differences were found with regards to the status prior to the reorganization. The third year became even worse, particularly due to unexpected reductions in indicators of community-based resources. Over time, more emphasis on so-called cost efficiencies, restricting expenditures and services overwhelmed the real clinical needs and clinical realities faced by the SLs. In short, SL implementation was associated with a decline in mental health expenditures relative to non-mental health services. This is a sobering reflection on changes that are made with the best of intentions but fail to meet their intended objectives. It is true that the development of SLs is a very uneven process throughout the 22 Networks in the VA system (themselves appropriately labeled as "22 individual experiments"), and that a hard look has to be taken at its theoretical, structural and operational bases. My opinion is that, unfortunately, each new administration in the VHA attempts to change things to leave a "legacy" or its stamp for posterity, with resulting confusion and demoralization, bordering on cynicism. I would reiterate that what is needed is the establishment of means and mechanisms to supervise structural developments and guide their advancement.

**Physical plants.** The physical plant of a number of mental health services in VA facilities require more attention. In cases, painting and cleaning efforts are accelerated each time that the Joint Commission for the Accreditation of Hospital Organizations (JCAHO) survey/visit is imminent. In cases, the facilities themselves are old and not fully used for such reason.

Other logistic concerns. Other suggestions concerning the logistic areas in the mental health sector of the VA include:

- a) The VHA should assess the long term care needs of veterans with serious mental illness by providing a detailed analysis of the need vs. availability of, for instance, psychiatric nursing home beds.
- b) The VA must ensure that the capacity of the Department to meet the needs of the veterans with serious mental illness is maintained in accordance with Congressional mandates. Monitoring compliance with the Capacity Law and the preparation of drafts of the capacity report should be the responsibility of an individual or a small group of individuals with active input from groups such as the SCMI.

- c) Mental Health Consumer Advisory Boards should be totally and fully implemented in all VISNs so that patients, veterans organizations, and community groups as well as other mental health advocacy entities can have a voice, and help direct the process of mental health care in the VHA system.

#### RESEARCH ASPECTS

Less than 9% of the VA health research budget is dedicated to mental illness and SA, even though 35–40% of VA patients need mental health care. These are the real facts, in spite of a most significant improvement in the area of mental health research in recent years—the creation of Mental Illness Research, Education and Clinical Centers (MIRECCs), modeled after the highly successful Geriatric Research, Education and Clinical Centers (GRECCs). This has mobilized an extensive set of potential research resources on specific areas, particularly in the Health Services Research (HSR) component. Mental Health has also a fair share in the Cooperative Studies and Rehabilitation research series. The Northeastern Program Evaluation Center (NEPEC) in West Haven, has made substantial contributions to the field. It is expected that two or three more MIRECC's will be funded in FY 2003 to get closer to the total of 15 envisioned by some VHA leaders. A 5-year funded follow-up study of medical problems in Vietnam veterans with PTSD will no doubt result in compelling findings.

**Mental health research strategy.** The methodological area of research is an important one addressed partly by the role of QUERI, a program aimed at developing quality of performance measures, particularly outcome measures that can clearly reflect the clinical, psychosocial, cultural, and environmental factors of disease, beyond some too general or gross parameters. Issues such as discharge criteria, quality of life, multiple diagnoses, comorbidity, psychosocial treatment approaches, ethnopsychopharmacology, drug interactions and side effects, economics of mental health care, and studies on specific entities with a truly clinical and epidemiological component are much needed.

The foregoing should not prevent the VA system from developing a truly strategic vision to strengthen mental health research. Sadly, such effort has not been sufficiently enhanced, and in some cases shallow reasons (i.e. "There are not too many mental health researchers in the system") have been provided to justify such inaction. After some promising developments in previous years, at this point the dialogue between the VA Research Office and the National Institute of Mental Health (NIMH) seems to be almost non-existent.

**Training of researchers.** Closely related to research efforts are the training needs of professional staff members. The VA should provide sufficient funding to the Office of Academic Affiliations for furthering Fellowships in the field of SMI patient care and other areas. Fellowships should also emphasize the multidisciplinary needs of effective mental health care, addressing the elements of a recovery- and quality of life-based care system, as well as evidence-based best practices in psychosocial rehabilitation. The VHA and its research arm also should encourage the academic affiliates to provide research funding from their own sources into veterans populations, considering the uniqueness of mentally ill veteran patients and the collaborative philosophy of these affiliations. Currently, such investment from the affiliated institutions is very small.

#### DYNAMIC ASPECTS

There are two clusters of dynamic issues within the system. One is the relationship between clinicians and administrators, and the other is the relationship between VA facilities and their academic affiliates. Both, I think, have significant impact on the overall development and functions of the VHA system and its provision of mental health care.

**Administrators and Clinicians.** It is no secret that there is a sort of "warfare" between administrators and clinicians in any healthcare system. From the mental health perspective, it seems clear that many administrators give preference to those considered "more powerful players". With all due respect to my colleagues in medicine, primary care, surgery, etc. mental health deserves better in the system. On the other hand, with very few exceptions, Service Line directors or managers have not been given budget authority to effectively handle the programs they lead. Management should be truly participatory. Experienced clinicians need to have the administrative tools and capabilities in order to review or veto non-clinician's approaches that are not going to work. If this is not done, I am afraid that there will be an adverse impact on the overall provision of mental health care. As the economy languishes in some areas, more and more veterans may turn to seek care in the VHA, thus creating more pressures, more demands, and more needs for which we

should be duly prepared. Because of the inherent weakness (voicelessness) of the veteran with mental illness, we have resorted to Congress on many occasions in order to strengthen our capacity, reinstate our losses, monitor our operations, etc.

Some administrators may also be passive instruments of an overall stigmatizing environment. A case in point is the excessive rulings about controls, seclusion and restraints, elopement control measures, etc. whenever applied to mentally ill vs. non-mentally ill patients. I would dare saying that prejudice against the mentally ill is still a powerful factor in some segments of the VHA staff.

**Administrators and patients and their families.** The same ambivalence is reflected in the way administrators deal with relatives of mentally ill veterans, whose participation is a crucial component of any management program. Our experience is that some VA administrators are not interested in developing ties with families of mentally ill veterans. Service organizations, organizations such as the National Alliance for the Mentally Ill (NAMI), the National Mental Health Association (NMHA), and community agencies should provide input and be active players in the management of our patients.

**VA and Academia.** The relationship between VA Medical Centers and the academic affiliates (whenever this occurs) is another field where dynamic factors play important roles. Let me make clear at the outset that I think academic affiliations are one of the greatest accomplishments of the VHA system throughout all its existence. They help to provide higher quality of care, exchange of knowledge, participation in the training of the future generations of professionals, and settings for joint research and educational programs.

Having said that, however, it is important to also acknowledge the very different, sometimes diametrically opposed agendas of the two components of this equation. The VA priorities are clinical first, educational and research second, whereas the affiliated institution's priorities are educational and research first and foremost, clinical care second. If we add the different administrative structures, then the stage is set for tensions that many times create the dilemma of divided loyalties, or force one to point out inadequate perceptions or procedures on the side of the academic institution. This "healthy tension" will be productive in the context of a balanced interaction between partners. While ultimately, this all may depend on individual personalities and interactive styles, this situation needs to be corrected. The marriage between VA and academia is essential but we need to do something to make it better.

**True integration is the name of the game.** There should not be different levels of "citizenship" in an academic affiliation, there should not be two standards of care. Vice Presidents for Health Affairs, Deans, Chairmen of Departments of Psychiatry and others in medical education institutions should address this divergence and make a definite statement about a philosophy of "one campus-one mission." Clinical and educational pathways should be created that adhere to this integrating philosophy which is basically a strategy to level the playing field. What is good for the patients at the Medical School should be good for the veterans and vice versa. Chairmen of Departments do not get Without Compensation (WOC) status in the affiliated VA Medical Center, and work alongside their counterparts in the VA clinical, educational, and supervisory activities. This is a barrier to collaboration. There should not be incongruities in how patients are handled, how patients are followed up, how psychiatry and mental health disciplines are taught in different settings. Getting credit for whatever work they do in either setting is crucial. The same applies to the teaching of medical students where performance improvement projects should be developed for the corresponding clerkships.

#### CONCLUSIONS

The American Psychiatric Association was one of the signatories of a letter dated April 3, 2002 and addressed to Mr. Principi, Secretary for Veterans Affairs. In that letter it was made clear the concern of all that the VA healthcare system was "failing to comply with its statutory obligation to provide needed services to veterans." The letter made clear that the Congress had twice amended the Capacity Law in order to fill gaps in the original legislation, delineating statutory responsibilities, making explicit that the department could not employ outcome data to meet the requirements to maintain program capacity, and delineating measures to maintain funding levels, program levels, staffing levels and patient workload. The sad reality, once again, was that some administrators at the Central Office as well as the Networks or even in local facilities were more than willing to close or reduce mental health programs going explicitly "against the letter and the spirit of the law which requires that the VA expands substantially the number and the scope of its specialized mental health and substance abuse programs so as to afford veterans real ac-

cess to needed specialized care and services". The Department's failure to allocate the necessary resources or even budget for them was in the opinion of the signatories "inexplicable and indefensible".

As a former employee of the VA system, I have to concur in general terms with the intent of this letter. Mental Health is still treated as a Cinderella, a younger sibling, a relegated component of a historically important system. While the situation is difficult, I don't think it is desperate or hopeless. There are very valuable members of the VHA family, at the administrative, clinical, and academic levels that want to do well and want things to improve. A lot has been done in terms of growth and consolidation of some MHSs, creation of true multidisciplinary teams, establishment of case management practices, the continuity of care philosophy, utilization of electronic documentations, expansion of some outpatient services and programs, pioneering research, and academic and scholarly accomplishments within the VA. One thing should never be forgotten: Veterans with mental illness are part of the so-called "Special Populations" in the VHA, patient groups that every DVA leader over the years has promised never to abandon. That does not seem to always be the case however, as we take an objective look at the system nowadays.

Much remains to be done in terms of clinical, logistic, financial, physical space, recruitment and retention of personnel, creation and sustainability of special programs, interaction with primary care and other non-psychiatric services, budget authority, equal partnerships, and removal of prejudices and discrimination towards the mentally ill veteran in some people's minds. On the basis of my testimony, the opening Executive Summary includes specific recommendations about mental health care in the VA system made on behalf of the American Psychiatric Association.

My experience at the VA has been extremely rewarding. My colleagues and staff have taught me lessons of honor, of courage, of dedication, of passion for the things they do, and the pathway they chose in life. We should continue fighting against biases towards the mentally ill, and attitudes that hurt and deny them the respect we should have for their suffering, their human dignity, their cultural background, their value as persons and human beings. We should continue working on trying to integrate the system, prevent budget cuts, create evidence-based research. It is not too late to right wrongs, and to make sure that we are true to principles of fairness, honesty, eagerness to learn and teach, love to our profession, concern for and commitment to our patients and their families. The journey of life is made up of encounters and separations, and they together create a path of hope for something better. A path always worth to walk in.

Thank you very much. I appreciate the opportunity to speak with you today on behalf of myself and the American Psychiatric Association.

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RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV  
TO RENATO D. ALARCÓN, MD, MPH

*Question 1.* Your testimony states that the VA's "emphasis on productivity and efficiency runs a collision course with quality." Can you give the Committee an example of this from your experiences at the Atlanta VA?

Answer. Productivity, understood, for instance, as number of patients admitted to an inpatient unit, or number of visits to the outpatient clinic, or number of patients seen per hour; and efficiency, considered as a reflection of an adequate "fit" between existing professional resources and volume of patients requiring services in any given health facility, are both technical or administrative terms frequently mentioned in the VHA as performance parameters for the clinical staff. The problem is that the measures or criteria used to establish supposedly acceptable levels for these parameters are arbitrary at best due to the abstract, impersonal way in which they are generated and conveyed to the field. Network and local facility administrators tend to enforce these expectations without paying due attention to the special and unique characteristics and needs of veterans with mental illnesses—the clinicians' main concern. The pressure to meet performance expectations forces clinicians to stretch their schedules (and their efforts) to see more patients in the same or even less time; or they may have to discharge patients earlier than medically indicated. In general, clinicians have fewer opportunities to provide the kind and level of treatment that patients require. Thus, quality of care suffers.

An example of this negative interaction in the Atlanta VA Medical Center was related to the closing of almost 50 beds in the inpatient unit at the beginning of the reorganization process (around 1996), and the simultaneous suggestion to shorten the patient's length of stay in the unit. Within a year from the implementation of this decision, the number of patients admitted to the unit in a 12-month period increased from less than 700 to more than 1200, which meant that work-ups, treat-

ment plans, and related inpatient clinical programs had to be intensified for each patient. Concomitantly, the number of outpatient visits increased from an average of 35,000 to more than 120,000 per year.

Professional staff members had not only to change work habits and focus but, most importantly, their numbers were not increased proportionately to such work increase. Our professionals worked harder, saw many more patients, had their schedules stretched to the limit, spent longer working day hours. Yes, their productivity increased, some administrators may even say that this represented a more "efficient" use of resources, but the fact is that we felt we were not doing everything that our skills would allow us to do for our patients, due to the pressures and demands that limited precious contact time with them. Quality of care suffered; there is no question about that. With such pressures and the reality of not doing their best for the patients, morale in the professional staff suffered.

*Question 2.* It is clear that there is futility in keeping mental health patients in the hospital if they do not need to be there. Frequently, mental health for even the very ill can be provided in an outpatient setting. Describe what the VA has done to make sure that their outpatient mental health care is just as effective as inpatient care.

*Answer.* This question is closely related to the previous one. It is true that in a number of cases and clinical conditions, good outpatient care is just as effective as outpatient care, and can generate savings overall. There is pertinent data in the literature to substantiate these claims. To balance out the impact of bed closing, the VA system fostered the growth and development of more outpatient programs including group therapy, psychoeducational activities, recreational therapy, and socialization efforts. The establishment of the Mental Health Intensive Case Management program may have been part of the same approach, even though its structure and operations, dictated by a strict technical protocol, can benefit only a limited number of patients. On the other hand, the numbers cited in my July 24, 2002 testimony and those of others in connection with the Substance Abuse Treatment Programs and the Methadone Clinics, offer another clear example of this. Once again, the lack of professional resources to implement and conduct additional programs, the lack of financial resources to hire qualified professionals, respond to increased space needs, acquire equipment and materials, etc. were factors that militated against the better intentions of the system. Yes, in some cases the readmission rate has not been as high as feared after bed closing; the number of ER visits for mental health patients has not increased dramatically; and the protests of veteran organizations have not been deafening. However, the waiting lists are longer, the level of satisfaction with outpatient care has decreased, and numbers of admissions of the same patients in geographically distant Medical Centers or figures of clinical occurrences such as suicide rates or levels of chronicity, may offer a different picture.

*Question 3.* Some inpatient mental health beds will always be necessary. Yet, in the VA, there is a tremendous propensity to cut these kinds of beds. How can the VA find the right balance?

*Answer.* The propensity to reduce inpatient beds is primarily related to the costs of inpatient care (estimated from US \$ 600 to 1200 per patient per day), the notion that in a number of cases outpatient care may produce similar results at lesser costs, and the decision to trim down segments of the federal government's bureaucracy. Unfortunately, in some cases, the trend may have been carried out excessively, or the move was not well evaluated in advance. The glut in demand for outpatient services noted above is one of its most visible consequences. Some steps that the VHA can take to right the balance includes:

- a. Deployment of adequate numbers of well trained personnel to outpatient areas
- b. Creation of new and intensive outpatient clinical programs
- c. Creation of additional assistance and psychoeducational programs with active involvement of families, veterans' organizations, and community agencies
- d. Networking with state and local mental health facilities for coordinated assistance to the needs of mentally ill veterans
- e. Re-evaluation of need to cut down beds on the basis of a systematic assessment of patients' clinical condition, severity, availability of alternatives, readmission rates, waiting lists, and other parameters. If necessary, after this analysis, reopen needed beds in some areas.
- f. Establishment of the continuity of care approach in clinical work, i.e., the assignment of patient cohorts to the same multidisciplinary teams in inpatient, outpatient and even community settings
- g. Intensification of efforts to improve sensitivity and awareness about mental illnesses and their management among primary care providers, so that beds other than psychiatric ones can be used for the care of dually diagnosed or

medically ill psychiatric patients. Outpatient management of some of these patients by non-mental health providers should also be promoted.

h. Re-examination of decisions made to provide care to veterans that have a lowest service-connection priority, and that have started to crowd service demands in detriment of those who are in most need and may require hospitalization or treatments that are more aggressive.

A number of these suggestions are based on the need to reinvest in mental health services within the VA, savings made through different measures in the recent past. It is well known that this has not happened. Maintenance of capacity mandated by law, accurate inflationary adjustments of capacity reports, continuous assessment of needs and care costs are urgent steps. Fair budget resources and specific allocations for mental health must reflect all of these needs and concerns.

Chairman ROCKEFELLER. Thank you, Doctor.

Colleen Evans, you are working in an Acute Schizophrenic Unit at Pittsburgh, so I am interested to hear what you have to say.

**STATEMENT OF COLLEEN EVANS, STAFF NURSE, ACUTE SCHIZOPHRENIA UNIT, VA PITTSBURGH HEALTH CARE SYSTEM, HIGHLAND DRIVE DIVISION, AND CHIEF STEWARD, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES**

Ms. EVANS. I would like to thank the members of this committee for providing me this opportunity.

I have worked at the Highland Drive site of the VA Pittsburgh Health Care System for 18 years as a registered nurse. I have worked in a variety of roles in both management and staff positions, in the care and treatment of mentally ill veterans. And, frankly, I am both angry and deeply saddened by the changes in the level of care that I have witnessed for this segment of the veteran patient population.

The loss of beds, programs and staff under the pretense of shifting to outpatient care mirrors the national image. The decrease in number of beds, psychologists, social workers and nurses have had a deleterious effect on both patients and staff. The decrease in psychologists has severely hampered our ability to provide intense one-to-one counseling. The loss of social work professionals has reduced our capacity to follow patients once they leave the facility. In addition to the actual social workers lost in real numbers, many of those that remain function in administrative rather than patient care roles. Patients are transferred to nursing homes, between nursing homes or discharged to the community and fall between the cracks, resulting in missed appointments, patients being without medication or worse.

Some end up in jail or living under bridges. A few commit suicide or are found dead due to an inability to manage their own care. Many self treat or self medicate, if you will, with alcohol or illegal drugs and show up months or years later with full-blown psychosis, cancers of the head and neck, and/or liver failure. We are concerned that the savings in resources resulting from the shift to outpatient care have not been committed to mental health. Outpatient intensive mental health care management has not become a reality for most of our patients.

And what staff find most frustrating and infuriating is that the management keeps pointing to performance measures, which they have established and do not measure the impact on patient care. The message that we are repeatedly given is that our concept of reality is severely distorted. It is like the shady bookkeeping that

apparently became popular in the corporate world. We are saying the sky is blue and they keep saying, no, it is black. Just look at these charts and graphs. In an effort to prevent——

Chairman ROCKEFELLER. Can you explain that? This will not reduce your time, but can you explain that a little bit more clearly so I understand it better?

Ms. EVANS. They have set up these performance measures and—should I just give you an example?

Chairman ROCKEFELLER. Yes.

Ms. EVANS. An example, recently, the facility stopped transportation for veterans. They used to provide transportation, and now they have—they have worked with the DAV to try to help them to do it. And it has created a major problem and difficulty for our patients to get to the facility now to receive their care. So in the past month our waits and delays have improved because approximately 355 patients could not get to their appointment because they had no way to get there.

In an effort to prevent duplication of services two units were merged at Highland Drive, resulting in the loss of any medical capability whatsoever. The sad result is that we are no longer able to care for our patient population that had medical diagnoses in addition to mental health concerns. Patients being bounced back and forth between sites to address their medical concerns remains a problem despite our efforts to address this issue. But the saddest scenario involves those patients we send over but cannot accept back due to a lack of medical capability.

It is not my intention to indict the concept of outpatient care. We wholeheartedly endorse and support the management of care as outpatients for those who are capable of keeping followup appointments, maintaining their medication regime and are not a danger to themselves or others, but with the resources to effectively follow and evaluate that ability, must accompany the philosophy. It is my intention to advocate as vigorously as I can for that part of the veteran population that is unable to say, "My symptoms are exacerbating. I think I should call my care provider." These are the most vulnerable of our patient population. These are the people that the VA must be there for, that do not show up on the performance measures because they do not come in.

The shift from inpatient to outpatient, as we see it, exists in theory only. It could be described as a shift from inpatient to non-patient. We currently have no inpatient beds for substance abuse, detoxification and rehabilitation treatment. The VISN is hoping the community will absorb our population, despite its admission that community resources are inadequate. The shifting between facilities, the lack of mental health services at CBOC's, the loss of programs and unavailability of staff has sent a clear message to mental health and substance abuse patients. We do not care about you.

To magnify that communication our patients recently lost all privileges. That means during the entire time they are inpatients in our units, they cannot smoke a cigarette, go out for a bit of fresh air or go to the canteen to purchase personal items unless they are accompanied by an escort. The loss of freedom has led to a loss of dignity and self respect. This injury to self image has negatively affected treatment and recovery. The confinement has led many pa-

tients to resist admission even though they are aware of an exacerbation of their symptoms. Many have made comments likening the units to being incarcerated. We believe it has also led to patients being discharged at their insistence before they are ready to go home. The loss of privileges has led to increased congestion on psychiatric units where patients, many with paranoid delusions, need space. Tension on the units has increased, and unit treatment programs has suffered as a result. One administrator made the comment that he had no doubt that we will see a serious decline in the number of patients seeking admission now that we have eliminated patient privileges. Whether by design or just as the unintended consequences of this decision, it is the firm belief of the staff that conditions are worse for our patients. It is in our best interest as a society to provide adequate care and treatment for this population. They have served their country when asked. We, at the very least, owe them the dignity of access to adequate and humane care.

I again would like to thank the members for this opportunity and ask for your continued support to help the most vulnerable segment of our patient population, the seriously mentally ill and the chemically dependent.

Thank you.

[The prepared statement of Ms. Evans follows:]

PREPARED STATEMENT OF COLLEEN EVANS, STAFF NURSE, ACUTE SCHIZOPHRENIA UNIT, VA PITTSBURGH HEALTH CARE SYSTEM, HIGHLAND DRIVE DIVISION, AND CHIEF STEWARD, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

Chairman Rockefeller and Ranking Member Specter, my name is Colleen Evans. For the past eighteen years, I have been a Psychiatric Registered Nurse at the VA health care system in Pittsburgh, Pennsylvania. I am also the Chief Steward of the Professional Staff unit of Local 3344 of the American Federation of Government Employees, AFL-CIO. Thank you for the opportunity to share with you what it is like on the front lines of mental health care at the VA.

I work on a secured acute psychiatric unit. The veterans I see in my nursing practice primarily carry the diagnoses of schizophrenia and schizo-affective disorder. Veterans admitted to my unit are at various levels of distress. Seventy percent of our patients voluntarily admit themselves for psychiatric care. My facility also treats patients with post-traumatic stress disorder (often referred to as PTSD) and severe mood-disorders, such as depression or bi-polar disorder. My facility also treats geropsychiatric patients, who are acute psychiatric patients who are over 65 years of age. My facility has no inpatient beds for long-term psychiatric care.

The veterans at my facility are among the roughly 455,000 veterans who suffer from a mental illness, which the VA has determined to be service-connected, that is, the illness was incurred or aggravated in military service. For these veterans the psychological wounds of war are very real, raw and ever present. Every day I see the courage of veterans with serious mental illness trying to stay connected to reality and to have a clear mind. Care of these vulnerable patients is at the heart of VA's mission.

Mental illness still carries a stigma in society. This stigma systemically undercuts mental health parity in the VA health care system as evidenced by:

- VA's termination of inpatient substance abuse treatment programs;
- VA's elimination of nearly all inpatient psychiatric beds under the pretense of shifting to comprehensive outpatient care, and;
- VA's failure to maintain an adequate complement of psychologists, social workers and nursing staff to handle the demand for intensive care from low-income veterans and veterans who are service-connected with mental illness.

As advocates for our patients, staff is angered, frustrated and deeply saddened by the changes in the level of care and access to care that we have witnessed for this vulnerable segment of the veteran population.

The elimination of inpatient medical beds has had a deleterious effect on the care of my patients.

The Pittsburgh VA health care system has three locations: the Highland Drive facility, where I work, which houses psychiatric and substance abuse treatment; the

Heinz facility, which provides geriatric and extended care; and, the University Drive facility, which is an acute medical care facility.

Most of our psychiatric and substance abuse treatment patients also have multiple medical diagnoses, which also require medical care. Many have infectious diseases, such as Hepatitis C, Hepatitis B and HIV. Because our patient population has multiple physical and mental conditions, the Highland Drive psychiatric facility at one point had a separate medical unit. The failure to provide prompt medical treatment to seriously mentally ill patients can thwart their psychiatric recovery and rehabilitation. For example, an untreated urinary tract can worsen psychotic hallucinations and lessen a patient's responsiveness to medications to treat their mental illness.

Staff on the medical unit at our psychiatric facility had expertise in dealing with the unique and complicated issues, which arise when treating the medical conditions of a psychiatric patient. Our medical unit was a secure ward.

In an effort to consolidate resources and save money, the VA decided to shutdown all the acute medical beds at our psychiatric facility. This has resulted in the loss of any capability to provide medical care within the psychiatric facility. Now we must transport our psychiatric patients to the VA University Drive acute medical care facility for treatment on units that do not have the staff, training, or resources to care for seriously mentally ill patients.

At times, we have sent a patient for medical care at VA University Drive and the patient has been refused admission. At times, patients are sent back to our facility without receiving the full complement of medical treatment they were supposed to receive. Why? These patients may be confused, acting out, having active hallucinations, combative and extremely difficult. The VA University Drive medical care center lacks the staff, and seclusion or observations rooms, that would allow these patients to be separated out from the general patient population and to be treated without risk to themselves or others.

The saddest scenario involves those patients we send over for acute medical care but can not accept back into our facility, due to our lack of medical care capability.

The purported reason the VA took away our medical beds was to prevent the costly "duplication of services." A secured medical unit specializing in the medical care of psychiatric patients is not duplicative of a medical care unit for the general population. While the VA may have reduced its bottom line, the closing of the medical unit at my facility has cost our patients dearly.

The abandonment of our inpatient substance abuse treatment program has hurt the recovery and rehabilitation of many veterans.

Approximately 68% of our patients with a mental health diagnoses also abuse drugs or alcohol. Many veterans self-treat or self-medicate their mental illness with alcohol or drugs. One veteran explained to me that he drank to drown out the voices in his head. The Highland Drive facility no longer has any inpatient beds for detoxification, substance abuse treatment, or rehabilitation.

Many veterans, especially homeless veterans, need the safe and supportive environment of an inpatient treatment program. VA management abolished the inpatient substance abuse treatment at the VA Pittsburgh health care system in 1998.

Our opiate treatment program, which helps veterans who are addicted to heroin, currently has a 3 month waiting list. Veterans often give up waiting and fall through the cracks. VA management wanted to contract with community programs for additional treatment slots but they are full. VA needs to increase its staff for this program in order to provide access to this effective program.

Until recently, patients on the acute psychiatric unit were able to participate in the outpatient substance abuse programs, including AA and NA meetings. Without advance notice or planning, our director instituted a policy that forbids us to allow our patients to walk themselves to the substance abuse treatment groups, even when assessed, evaluated and approved to do so by the clinical care team.

At first, staff would escort acute psychiatric care patients to the outpatient substance abuse program in order for our patients to have access to this treatment program. Because we lack adequate staff to provide constant escort by staff of our inpatients during the short breaks in between treatment groups they are in fact barred from participating in the programs at our Center and Treatment for Addictive Disorders. We simply do not have enough staff to make treatment accessible under this policy.

With no inpatient substance abuse treatment and with a policy that effectively bars our patients from accessing the out-patient substance abuse treatment, our acute psychiatric patients are being denied treatment that is necessary for their full recovery and rehabilitation.

In the short-run, management has arranged for a social worker to come to a unit 3 days a week for half an hour to lead a group of patients to help them get moti-

vated for treatment. Once motivated, if they remain an inpatient, they cannot receive treatment.

The across-the-board elimination of the privilege of a patient to go off the unit has adverse ramifications for staffing levels, access to care and quality of patient care which are not being adequately addressed.

The policy to bar all psychiatric patients, who are admitted to the acute unit, from the "privilege" of going off the unit has implications beyond the denial of access for substance abuse treatment. All patients on these units are forbidden from escorting themselves to any therapy off the unit, regardless of whether they are no longer in an acute status. Because staffing on the unit is already extremely tight, it is difficult for us to escort patients to occupational therapy, recreational therapy, or kinesiotherapy. Therefore, patients miss appointments and we are effectively denying veterans access to the comprehensive care they deserve. When we divert nursing staff to escort patients off the unit, it further cuts our staff for therapeutic interventions and to respond to psychiatric emergencies, leaving patients and staff at risk.

The barring of the privilege to go off the unit unaccompanied, also effectively means those patients can no longer go smoke a cigarette. While that seems like a minor inconvenience, at worst, and at best the promotion of a healthier lifestyle, it is devastating to our patients. Research has shown that the addictive force of nicotine is stronger and, therefore, harder to break for schizophrenics. Smoking helps reduce the agitation of psychiatric patients and calm them. Before or after the immediate imposition of the new policy on privileges, management did not arrange to increase escort staff or to provide a secure day room with proper ventilation for smoking.

The increased confinement on the units has heightened tensions and unit treatment programs have suffered. Recently staff had to break up four different altercations between patients on my unit. Before the no-privileges policy, we had fewer altercations.

Many patients have expressed to me that they feel they are being punished and penalized. Out of the frustration at the stigma attached to not being able to earn the privilege or trust to go for treatment, one patient told another nurse "It's like jail, but I'm supposed to be in a hospital. At least in jail, trustees get out of the cells." The confinement has increased depression for patients and reduced overall functioning levels.

Because of the lack of privileges, patients are seeking discharge sooner than medically warranted. One administrator made the comment, "I have no doubt that we will see a serious decline in the number of patients seeking admissions now that we have eliminated patient privileges."

When the psychiatric care team evaluated a patient to be eligible for privileges, we did so as part of the therapeutic process. The psychiatrist made the case-by-case decision to grant or refuse a patient's privilege of leaving the unit unescorted. When clinicians granted privileges, it was to patients who were following protocols, compliant and responsive to medications and actively engaged in unit therapies. The psychiatric team also used privileges to evaluate how an individual patient functioned, for short exposures, with outside stimuli. The granting of privileges allowed patients to take a small step back towards normalcy, increase their self-esteem and self-accountability.

Nursing staff would take away a patient's privileges when there were indicators that the patient was not behaving appropriately on or off the ward or not acting responsibly.

VA management is not applying its policy uniformly. It applies only to patients at my facility at Highland Drive. When we send many of our psychiatric patients for medical care at the VA's University Drive facility they have full privileges. This disparity in treatment further confirms to patients that the VA is punishing them for their mental illness.

I appreciate that the policy to bar psychiatric patients from leaving the unit on their own was established with patient safety as the objective. As a psychiatric nurse for two decades, I am fully aware of the potential danger some of our patients can be to themselves, staff, or other patients. As a psychiatric nurse, I appreciate that among patients admitted to an acute care unit there is a broad range of functioning levels. I am also keenly aware of the common prejudice to label all patients with psychiatric disorders as dangerous individuals who we should lock up in the back wards of asylums.

But in the 21st century, we should know better. Seriously mentally ill veterans deserve to be treated with dignity.

Staff are frustrated that the current policy on privileges was not thought out fully to ensure that our patients receive the comprehensive care they need. We are exasperated that VA management did not increase our staffing levels to deal with the

ramifications of an indiscriminate no-privileges policy. We are troubled that the policy was developed and implemented before allowing input from psychiatric care staff. We are alarmed that the policy was put into effect immediately without any planning to address the adverse consequences to patients and staff.

In February 2002, more than 200 staff signed a petition urging our Director to adopt a Patient Privileges/Responsibilities Policy developed by a team of mental health professionals at our VA facility. Staff firmly believes that the principle of the least restrictive care environment, as cited in our health care systems Patient Bill of Rights will lead to improve patient outcomes.

We ask for your assistance in encouraging our Director to adopt the policy developed by psychiatric care staff.

Deinstitutionalization, rehabilitation, outpatient care, and extended care

The VA has rapidly "deinstitutionalized" our most impaired mentally ill patients. According to the Committee on Care of Veterans with Serious Mental Illness, the number of patients with psychoses treated as inpatients dropped from FY 1994 to FY 2000 by 34%. In addition, the length of the stay of these veterans has been shortened significantly. VA has also shifted to outpatient and community settings as its primary care delivery model.

These trends may seem to be a promising shift from institutional care to treatment and care in the community but in reality VA has failed to maintain sufficient staff to ensure these vulnerable veterans receive the comprehensive continuum of care and support to function in the community.

At my facility, we had an extended care unit with 27 beds to care for veterans who were chronically mentally ill and were treatment resistant. Veterans on this unit had psychoses, dementia and Huntington's Chorea. This unit rarely had unoccupied beds. In March 2001, staff worked aggressively to discharge nearly half these patients to nursing homes and personal care homes in order to drop the census of the unit down to 17.

The reason VA pressed to discharge these patients was to make room on the unit for new patients who would benefit from the state-of-the-art care in the unit as it became the Psychiatric Recovery Enhancement Program or PREP. The PREP is an intensive patient-centered rehabilitation program designed to achieve the highest function levels for patients in the least restrictive environment. Unfortunately, the chronic mentally ill patients who we discharged to make room for the PREP program did not benefit from that program.

Many of the facilities that received these patients have sent them back to the VA because the patients were too disruptive or combative. The VA is often the only place willing to provide care for these patients. But now we are often turning our backs on veterans who need extended psychiatric care. Unless a veteran is 70 percent service-connected, the VA extended care facility in Pittsburgh will force the patient and his family to plead every 60 days for the veterans' continued care.

One veteran's wife told me she felt like she was sitting in front of a Gestapo committee of administrators telling her that her husband had to get out. Her agony was due to the fact that her husband was beaten and abused when he would strike out at a caregiver in a private nursing home. The private nursing home staff put him in a straight jacket. The care he received at the VA was far superior.

Instead of closing mental health beds the VA should convert, these beds into extended care and long-term care beds. The final days of a veteran's life should not be filled with uncertainty and fear over whether they can stay at the VA. AFGE is concerned that the Capital Assets Realignment for Enhanced Services, or CARES process, will worsen this situation by closing down more beds.

The reduction in staff has limited and hurt our capacity to provide this intensive treatment to help patients move back into the community when feasible. We are under new universal staffing levels, which will increase the number of patients per nursing staff. This reduction in staff per patient will make the goals of rehabilitation and recovery even more difficult to achieve.

The loss of social work professionals has reduced our capacity to follow patients once they leave the facility. In addition to the actual social workers lost in real numbers, many of those that remain function in administrative rather than direct patient care roles. Without adequate staff to help manage the cases of patients who are discharged into nursing homes or the community, we risk many veterans falling through the cracks. These patients end up in jail or living under bridges. A few commit suicide, others self-medicate with illegal drugs or alcohol, others will show up later at a VA facility with full blown psychosis, cancer and/or liver failure.

The community based outpatient clinics (or CBOCs) have consistently failed to provide adequate access to mental health services. My service network, VISN 4, has ranked 20th out of 22 networks in deployment of mental health services at CBOCs.

It is clear that VA saved dollars by the elimination of staff and beds for mental health but did not retain those dollars to support specialized mental health care capacity. VA instead funneled funds to support medical care.

The shift to outpatient care or discharging patients into the community is a pretense and renders veterans non-patients if the VA does not provide adequate staff and resources to engage in active and intense case management.

#### CONCLUSION

Veterans served our country when asked. We, at the very least, owe them the dignity of access to adequate and humane care. We cannot let the most vulnerable segment of our patient populations, the seriously mentally ill and the chemically dependent, fall through the cracks because we lack the commitment to staff the VA and re-open beds.

Chairman ROCKEFELLER. Thank you. But please continue your good work with the VA.

Ms. EVANS. I am trying.

Chairman ROCKEFELLER. OK, thank you.

Dr. Frese.

#### **STATEMENT OF FREDERICK FRESE, VICE PRESIDENT EMERITUS, NATIONAL ALLIANCE FOR THE MENTALLY ILL, AND ASSISTANT PROFESSOR OF PSYCHOLOGY IN CLINICAL PSYCHIATRY, NORTHEASTERN OHIO UNIVERSITIES COLLEGE OF MEDICINE**

Mr. FRESE. I am real honored to be here. I am with NAMI, Senator Rockefeller, and the last 10 years we have been very active in the Senate. We have looked at Senators Pete Domenici and Paul Wellstone as being our champions. We call them St. Peter and Paul. But from my observation of you this morning, sir, you are definitely moving closer to those pearly gates, so thank you very much. [Laughter.]

You are doing outstanding work here. In addition to being the recent Vice President of the NAMI board of directors and a veteran, I am a retired captain from the U.S. Marine Corps. I retired during the Vietnam war when I was a guard officer guarding intelligence facilities and atomic weapons, because I received a medical discharge because I was diagnosed with schizophrenia. I am wearing a suit, but it is not PTSD this time, Senator.

In this condition in the past I have been involuntarily hospitalized numerous times in military state, county, private and veterans hospitals during the past three decades while working as a psychologist in state hospitals and community mental health centers. I have been receiving outpatient treatment from the Veterans Administration for my schizophrenia.

Over the years I have served on numerous advisory panels for the VA including the Committee on Care for the Seriously Mentally Ill, the SCMI Committee, and the National Psychosis Algorithm Project. Today I would like to focus my testimony on continuum of care needed for veterans with severe mental illnesses and the VA's capacity. Of great concern to NAMI is about 30 percent of veterans who are service connected, or for psychosis, about 25 percent of the total are for those with schizophrenia, often considered the most devastating of the brain disorders, but in my case I am not as disabled as many of my fellow schizophrenic veterans.

In NAMI's view, an acceptable continuum of care should include availability and accessibility of professionals in care and we would

like to highlight the following things. One is adequate medications, which have been addressed already. Family, education and psycho-education, which has not been mentioned which is a major focus. Some of the VISN's have it and some do not, but families should be much more knowledgeable about our understanding of schizophrenia and serious mental illness than they have been, particularly with the late breaking news out of Decade of the Brain.

Chairman ROCKEFELLER. Can I interrupt you, no expense to your time, just to explain how that works in the best possible way, family involvement?

Mr. FRESE. Yes, sir. Until 20 years ago, families, including my own, would not talk about mental illness at all. It was totally taboo. Families would not acknowledge they had insanity in the family. That has changed somewhat in the last 20 years. Now families are willing to take more—acknowledge that they have this condition and take more interest in their persons with mental illness in the family and particularly with the VA, but the VA is following customs that was set after the war and this has not been incorporated. So in one of the VISN's, Vincennes, they are moving well on this, but the rest are not, and that is to bring the families into the treatment process and make sure the families understand the nature of the disorder. Understanding what a broken leg or blindness is, is kind of intuitive to most persons. Understanding what schizophrenia is, is much more difficult. I often say handicapped parking spaces do not have an image of a Haldol pill, because that would not signal. It is very difficult for folks to understand. Families need to know more about this.

Am I responding to your question?

Chairman ROCKEFELLER. So in other words, the point is, that to have families come for the treatment sessions, is as much or more for them and their evolution and support capacity as it would be for you as a patient.

Mr. FRESE. Yes, sir. Very good.

In addition to focusing on family education and involvement, there are the CBOC's, the outpatient care. By the way, we are still concerned that only 46 percent of those community based centers offer outpatient treatment for psychiatric disorders. A year ago that was 40 percent so it is moving up a bit, but that is a concern. We are concerned about residential treatment and supporting housing.

In the advocacy movement we generally say three things we want are housing, jobs, and by stigma, and housing for the VA is a problem.

The ACT's or MHICM's that you have heard about are exceedingly important. You have heard there are 65 of them, but of the 21 VISN's, some of those do not have any at all. You have also been told that professionals are involved in that, psychiatrists, psychologists. I am very concerned personally that only a handful of psychologists, very few, are involved in those at all, and we need much more support from psychology on getting psychological services in the VA as elsewhere.

Psychosocial rehabilitation, particularly focused on the recovery movement, it is totally a news flash to most providers that those of us with schizophrenia do not have what is characterized traditionally as a degenerative disorder. We can recover, and I was so

please that Dr. Lehman and others allowed Moe Armstrong and I to give a national teleconference, and he signaled to the VA we are going to change from focus on care and maintenance to a focus on trying to get folks to recover. We can recover, and with their help, we can do that.

Ms. Evans pointed out about the prejudice and stigma within the VA, and others have as well. That is a problem. I think the President's Commission, Mr. Bush says the main three things that need to be focused on are stigma, capacity and parity, that stigma is something that needs to be addressed throughout, particularly in the VA. Those attitudes need to be changed. I do not like going and getting services and being referred to as a schizo to my face. If you want to call me a person with schizo, that is something else, but those terms need to be toned down.

Employment services, we need to work. Seriously mentally persons throughout the—

Chairman ROCKEFELLER. The medical staff would not refer to you that way, would they? Who would use those words?

Mr. FRESE. Most recently?

Chairman ROCKEFELLER. Yes.

Mr. FRESE. Most recently I was in this town 2 weeks ago, testifying before a Presidential commission and a member told me he was real happy that he had just gotten a job for 2 schizos and would that not make me happy? And I told him, well, I am happy you got jobs for a couple of us, but I would really prefer you characterize us with a term other than schizo. I am sorry, but I am sensitive about these terms. But thank you for your interest. I do not want to be angry here because I appreciate all your work.

Integrated treatment. This is new. It is designated by the American Psychiatric Association as one of the evidence-based practices. There has been separation of treatment for those with substance abuse and serious mental illness. Those of us with these illnesses are exceedingly vulnerable to the effect of those substances, alcohol and treatment drugs, but we need to be treated with those together. 60 to 70 percent of us with serious mental illness also have substance abuse problems, and those need to be better integrated.

Now, those are our major issues. I have them all in the written statement. The MIRECC's, the research, we are very pleased there 8 MIRECC's and there is efforts to increase that research. We in NAMI particularly look forward to all the research findings. We are benefiting tremendously from the quintupling of the budget for NIMH in the last 10 years, and we are learning about what is going on in the brain. But the VA has been a substantive part of that research effort and that has got to keep coming.

I have a concluding paragraph. I am over time. Would you like to hear it, sir?

Chairman ROCKEFELLER. Are they just polite or are they substantive.

Mr. FRESE. Our Nation's veterans deserve the best treatment including access to the highest quality care for goods and services. Thank you very much, sir.

[The prepared statement of Mr. Frese follows:]

PREPARED STATEMENT OF FREDERICK FRESE, VICE PRESIDENT EMERITUS, NATIONAL ALLIANCE FOR THE MENTALLY ILL, AND ASSISTANT PROFESSOR OF PSYCHOLOGY IN CLINICAL PSYCHIATRY, NORTHEASTERN OHIO UNIVERSITIES COLLEGE OF MEDICINE

Chairman Rockefeller, Senator Specter and members of the Committee, I am Fred Frese of Akron, Ohio. I am pleased today to offer the views of the National Alliance for the Mentally Ill (NAMI) on the Department of Veterans Affairs ability to deliver quality mental health care to veterans with severe mental illnesses.

In addition to having served on the NAMI Board and the VA's Consumer Liaison Committee on Care of Veterans with Serious Mental Illness. I am a veteran myself. In 1966, I had been selected for promotion to the rank of Captain in the U.S. Marine Corps. That is when I was first diagnosed as having the brain disorder schizophrenia—perhaps the most severe and disabling mental illness diagnosis. Since my original diagnosis, I have been treated within the VA medical system, both as an inpatient at the VA hospital in Chillicothe, Ohio, and as an outpatient. Over the years, I have served on numerous advisory panels to the VA on care for the seriously mentally ill, including the VA's National Psychosis Algorithm.

#### WHO IS NAMI?

NAMI is the nation's largest national organization, 210,000 members representing persons with serious brain disorders and their families. Through our 1,200 chapters and affiliates in all 50 states, we support education, outreach, advocacy and research on behalf of persons with serious brain disorders such as schizophrenia, manic depressive illness, major depression, severe anxiety disorders and major mental illnesses affecting children.

NAMI has established a NAMI Veterans Committee to assure close attention to veterans mental health issues not only at the national level, but also within each Veterans Integrated Service Network (VISN). The NAMI Veterans Committee includes members in each of the 21 VISNs who advocate for an improved continuum of care for veterans, active military, and dependents with severe mental illness. The membership of the NAMI Veterans Committee consists of persons with mental illness, or family and friends of a person living with a severe mental illness who have an active involvement and interest in issues impacting veterans and our military. NAMI is therefore pleased to offer our views on the programs that serve veterans with severe mental illness.

Mr. Chairman, today I would like to focus my testimony on the continuum of care needed for veterans with severe mental illnesses and the VA's capacity to provide quality mental health services. For too long, severe mental illness has been shrouded in stigma and discrimination. These illnesses have been misunderstood, feared, hidden, and often ignored by science. Only in the last decade have we seen the first real hope for people with these brain disorders through pioneering research that has uncovered both biological underpinnings for these brain disorders and treatments that work. NAMI applauds the contributions of VA schizophrenia research to the understanding and treatment of these illnesses and supports the development of the VA mental illness research infrastructure through the Mental Illness Research, Education and Clinical Centers (MIRECC). NAMI is also grateful to the efforts of Congress (under your leadership, Senator Specter) to double the funding at the National Institute of Mental Health on mental illness research.

#### CONTINUUM OF CARE FOR VETERANS WITH SEVERE MENTAL ILLNESS

In NAMI's view, an acceptable continuum of care should include the availability and accessibility of physician services, state of the art medications, family education and involvement, inpatient and outpatient care, residential treatment, supported housing, assertive community treatment, psychosocial rehabilitation, peer support, vocational and employment services, and integrated treatment for co-occurring mental illness and substance abuse. The services a veteran requires from this continuum of care at any given time are determined by the fluctuating needs of his or her current clinical condition and should be established in conjunction with his or her treatment team. All services should be available without waiting lists or other barriers to accessing needed treatment and services. To be a comprehensive system of care—the VHA must have the capacity to provide such services.

Mr. Chairman, as you know the VHA's 21 VISNs were instituted to administer the health services (including mental illness treatment) for VA hospitals and clinics. The idea of these VISNs was to decentralize services, increase efficiency and shift treatment from inpatient care to less costly outpatient settings. There is great variation within and between each VISN in the services it offers to veterans and a VA mental health benefits package can vary from network to network. Further, the

VHA is in charge of allocating annual appropriations for each of these 21 VISNs, but does not specifically direct funds to be spent for mental illness treatment and services. Once funding is received, each VISN has authority to allocate resources to hospitals and clinics within their jurisdiction with broad autonomy. NAMI's concern is that with the flat or declining budgets in each VISN veterans with severe mental illness will not receive the treatment that is needed.

In NAMI's opinion, the lack of access to treatment and community supports for veterans with severe mental illness is the greatest unmet need of the VA. The FY 2003 Independent Budget for the VA estimates that 454,598 veterans have a service connected disability due to a mental illness. Of great concern to NAMI are the 130,211 veterans who are service connected for psychosis, 104,593 of whom were treated in the VHA in FY99 for schizophrenia, one of the most disabling brain disorders.

#### VA MUST EXPAND EVIDENCE BASED SERVICES

As part of P.L. 107-135, Congress directed the VA to provide data on how VHA is maintaining capacity for this high priority category of veterans through specialized services. This law mandates, among other provisions, that VA provide data on the number of Mental Health Intensive Case Management (MHICM) teams, the number and type of staff that provide specialized mental health treatment in each facility and Community Based Outpatient Clinic (CBOCs), and the number of CBOCs that provide mental health treatment and services. NAMI remains hopeful that this data will help define how capacity is being maintained for veterans with severe mental illness. At the same time, we have to recognize that without the VA's expanding services and programs and providing further resources and funding, the VA's capacity to serve these high priority veterans will never be met.

#### MENTAL HEALTH INTENSIVE CASE MANAGEMENT

As members of this Committee know the VHA issued a directive for Mental Health Intensive Case Management (MHICM) back in 2000. MHICM is based on the Substance Abuse and Mental Health Services Administration's (SAMHSA) standards for assertive community treatment (ACT), which are proven, evidence-based approaches in treating the most severe and persistent mental illnesses. VHA data shows that assertive community treatment is cost-effective as well as effective in treating severe mental illness. However, the SCMI Committee reports that only 1% of all veterans with severe mental illnesses are being treated by a MHICM team. Over 12,000 veterans meet the criteria for MHICM and yet only 2,905 veterans are enrolled. Several networks do not have any teams in place at all.

It is also recognized that very few of the MHICM treatment teams meet the SAMHSA standards outlined in the VA directive and that many of these teams are operating at minimal staffing and are now facing further staff reductions. NAMI strongly recommends that Congress direct VA to dedicate new resources to provide the essential number of new intensive case management teams and to fully staff existing teams so that our nation's most vulnerable veterans receive appropriate and coordinated care.

#### COMMUNITY BASED OUTPATIENT CLINICS

Many of the VA's Community Based Outpatient Clinics (CBOCs) are instituted in areas where VA health services are not easily accessible. However, the SCMI Committee reports that out of the 560 CBOCs in operation only 46% offer minimal treatment services for veterans with severe mental illness. NAMI is truly concerned that meaningful community-based capacity is not being developed to treat chronically mentally ill veterans in their communities. NAMI agrees with the SCMI Committee recommendation that VHA should assure that adequate funds are available in each network to implement plans to provide mental health services for high priority veterans. The SCMI Committee has recommended that this be done even if it means requiring mandates for VISNs to reprioritize current funding for services of lower priority veterans and slow further growth of spending on lower priority veterans.

#### ACCESS TO APPROPRIATE MEDICATIONS

Critical to a continuum of care for veterans with severe mental illness is access to the most appropriate medication. NAMI has closely followed the implementation of the VA's prescribing guideline for atypical antipsychotic drugs and the subsequent GAO report (GAO-02-579) requested by House Veterans' Affairs Committee Chairman Chris Smith. The GAO investigated if this guideline has resulted in re-

stricted access to more costly antipsychotic medications and the possible adverse effects this may have on veterans with severe mental illness.

Mr. Chairman, NAMI is pleased that the GAO validated three of our primary concerns surrounding the guideline since it was first issued in July, 2001: (1) that selecting which antipsychotic agent to prescribe is difficult and patient specific, (2) that the most desirable outcomes are very much determined by a clinician's ability and freedom to properly match the right patient with the right medication, and (3) that while the intent of the overall guideline may be to ensure physician judgment is the driving factor in decisions, there exists a great potential for abuse of the guideline from VISN to VISN and facility to facility.

The GAO report found that "VA's guideline for prescribing atypical antipsychotic drugs is sound and consistent with published clinical practice guidelines commonly used by public and private health care systems." NAMI is troubled by this assertion and believes that is inconsistent with the current research base. Medical evidence supports the use of an atypical antipsychotic as the medication of first choice, but current guidelines based on this evidence specifically provide for clinician choice among the atypicals (other than clozapine). In NAMI's view, the VA guidelines go beyond the medical evidence in that they select preferred atypical medications based solely on cost.

NAMI continues to be concerned regarding this policy and questions whether VA would make cost a consideration in the treatment of any other group of service connected veterans. While NAMI supports the VA's overarching goal to allow physicians to use their best clinical judgement when prescribing atypical antipsychotic for their patients, and while we certainly recognize the VA's need to husband resources, we believe that it should not come at the cost of veterans with acute needs.

There are numerous studies (including the schizophrenia PORT study) demonstrating that these pharmacy costs are only a small part of the cost of schizophrenia care that can include hospitalization, residential care, supportive services, etc. Pharmacy savings that are achieved through restrictive formularies are often offset by increased clinical care costs elsewhere. Such studies do suggest the importance of looking at the costs of the entire care system for an illness, rather than trying to control costs in just one area.

Unfortunately NAMI was not surprised by the GAO's finding that numerous VISNs have implemented procedures that "have limited or could restrict access to certain atypical antipsychotic drugs on the VA's national formulary because of cost considerations." NAMI continues to receive reports from families, consumers receiving services, as well as physicians providing services within the Veterans Health Administration that speak of further restrictions on accessing medications and clinical decisions that are overridden by pharmacy managers.

Mr. Chairman, we recommend that this Committee urge the VA to develop and implement a detailed plan to stop abuses found in the GAO study. The GAO report recommends that the "VA monitor implementation of the guideline by VISNs and facilities to ensure that facilities' policies and procedures conform with the intent of the guideline by not restricting physicians from prescribing atypical antipsychotic drugs on VA's formulary." NAMI fully supports this recommendation and believes that, at a minimum, there should be:

- a directive forbidding the collection and use of individual physician prescribing profiles
- a directive forbidding the introduction of cost-containment criteria into performance reviews
- a formal monitoring program to examine all instances in which a less expensive medication is substituted for a more expensive medication to assure that stable patients are not switched
- a formal program by which violations of these directives by overzealous pharmacy or behavioral health managers could be reported without fear of reprisal.

#### FAMILY EDUCATION

There is broad research that demonstrates family psychoeducation and support services offered to the families of veterans with severe mental illness should be a part of a continuum of care for veterans. Family psychoeducation includes teaching coping strategies and problem-solving skills to families (and friends) of people with mental illnesses to help them deal more effectively with their ill relative. Family psychoeducation reduces distress, confusion, and anxieties within the family, and can often help the veteran recover. However, family psychoeducation is rarely offered in the VA setting and there are limited incentives to do so. To fill this void, NAMI has partnered with the VA to offer family education through the Family-to-Family Education Program, (a model that has proven effective at improving the ex-

perience of families of persons with serious mental illness). Research has shown that this course provides knowledge to families and empowers them to cope with their ill family member and the mental health system in a positive manner, and has lasting effects on the family system.

The VA has 21 health care networks with 163 hospitals, 800+ community-based facilities, and 135 nursing homes and more than 454,000 veterans service connected for a mental illness. This represents a critical mass of individuals who could benefit from family education. The SCMI Committee recommended in its 5th Annual Report to the Under Secretary that VA develop partnerships with community organizations that sponsor self help groups and that they be a specific item required in the annual Network Strategic plan. NAMI further recommends that VA encourage the use of family education and family support services in each Network.

#### IS THERE PARITY IN THE VA FOR MENTAL HEALTH?

NAMI greatly appreciates the efforts of this Committee and Congress to address the loopholes that have existed in the Capacity Law. Last year, Congress passed the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (PL 107-135) which strengthened the VA's capacity to serve veterans with mental illness; requiring improvements to the current system to ensure that veterans have access to the necessary treatment and services. The new law not only requires the Department to maintain capacity for veterans with mental illness but also to replace lost capacity. The FY 2003 Independent Budget (IB) makes several recommendations for increasing the VHA's capacity to serve veterans with mental illness. Moreover, the IB recommends that to simply achieve parity with other illnesses, the VA should be devoting an additional \$478 million to mental illness spending. NAMI supports the IB recommendation for the VA to meet its responsibility to these high priority veterans. To achieve this goal, Congress should incrementally augment funding for veterans with severe mental illness by \$160 million each year, beginning in FY 2003 through FY 2005.

Currently, about 20% of veterans in the VA system are in need of mental health treatment and far below the expectations of the VA's capacity law. At the same time, funding for mental health has declined by 8% over the past five years (adjusted for inflation that decline in spending increases to 23%). While the VA reports that they have maintained capacity for veterans with severe mental illness, many advocates argue that the VA has not due to the high need of expanded services, decreased staffing levels, and budget levels that are not adjusted for inflation.

Further, the VA's funding model, the Veterans Equitable Resource Allocation (VERA) system also provides disincentives for providing mental health treatment. VERA under-funds the cost of providing services to veterans with severe mental illness by 20%. In FY 2000, an additional \$498 million was needed to make the VERA allocation equal to the costs of its mental health cohorts. NAMI strongly supports the SCMI Committee's recommendation that the VHA ensure that the funding model is cost neutral for care of veterans with severe mental illnesses.

#### RESEARCH

Even though the VA has made genuine progress in recent years in funding for psychiatric research, such research remains disproportionate to the utilization of mental illness treatment services by veterans. Veterans with mental illness account for approximately 25% of all veterans receiving treatment within the VA system. Despite this fact, VA resources devoted to research has lagged far behind those dedicated to other disorders.

For FY 2003, NAMI urges Congress to support the recommendation of the Independent Budget and Friends of VA Medical Care and Health Research to increase the overall VA research budget by \$89 million. Psychiatric research dedicated to chronic mental illness, substance abuse and PTSD has remained relatively flat for last 15 years, despite the fact that the number of patients in the VA system receiving mental illness treatment has grown. Research is one of the VA's top missions and NAMI is pleased that the VHA is taking steps to increase the number of Mental Illness Research, Education and Clinical Center (MIRECCs), centers designed to serve as infrastructure support for mental illness research. The MIRECCs are a tremendous resource for improving the efficacy of mental health services and improving the outcomes of veterans living with severe and persistent mental illnesses. Mr. Chairman, NAMI appreciates the efforts of Senator Specter and yourself to urge your Senate colleagues on the VA-HUD Appropriations Subcommittee to increase VA's medical and prosthetic research program in FY 2003.

## LOST CAPACITY FOR SUBSTANCE ABUSE TREATMENT

There has been a tremendous decline in substance abuse services. Since FY 1996 the number of veterans treated has declined by 14% and funding for services has declined by more than 50% is despite evidence that substance abuse disorders are increasing across the nation.

Further, in 1999 Congress passed the Veterans Millennium Health Care and Benefits Act (P.L. 106–117) mandating that by FY 2000 VHA increase funding for both substance abuse and PTSD by at least \$15 million dollars each year. To date, VHA has yet to meet that mandate.

NAMI supports the recommendation of the SCMI Committee “that assertive management action needs to be taken to reverse the ongoing erosion of access to specialized substance abuse services in VHA. This action needs to restore services to the 1996 levels mandated in the Capacity Provisions of the Eligibility Reform legislation.”

## CO-OCCURRING DISORDERS

National studies commissioned by the federal government estimate that 10–12 million Americans have co-occurring mental and addictive disorders. The prevailing research confirms that integrated treatment for co-occurring disorders is much more effective than attempting to treat these illnesses separately. In NAMI’s view, the research clearly demonstrates that providing treatment and interventions for mental illness and addictive disorders simultaneously, at the same treatment site, and with cross-trained staff is more effective than sequential treatment (treat one disorder first, then the other) or parallel treatment (in which two different treatment providers at separate locations use separate treatment plans to treat each condition separately but at the same time).

NAMI supports the research being done in the MIRECCs to improve the health services for patients who have co-occurring mental and addictive disorders. For example, the VISN 1 MIRECC has concluded that emphasis should be placed on integrated treatment, and that attention to a veteran’s multiple disorders produces better outcomes. The VA needs to continue to develop innovative programs and appropriately train staff to help veterans living with a severe mental illness and an addictive disorder.

## CONCLUSION

Mr. Chairman, NAMI appreciates your dedication to veterans with severe mental illness and your sponsorship of legislation to further improve and expand the provision of specialized mental health services to veterans. Our nation’s veterans deserve the best treatment, including access to the highest quality care, supports and services. Veterans with severe mental illness should be afforded the same resources as other high priority veterans, including needed community based supports and access to state of the art medications. Thank you for the opportunity to share NAMI’s views on these important issues.

Chairman ROCKEFELLER. Thank you. Thank you, Dr. Frese.

And before I go to you, Mr. Armstrong, I want to ask you, Dr. Alarcón, two things. We have heard the words here “mental illness” and we have heard the words “serious mental illness.” I am a lay person, so just explain to me those two categories and how I can best understand the difference.

Dr. ALARCÓN. There are maybe two levels of explaining that. One is what we clinically may consider a severely mentally ill versus a mentally ill patient, and what the rules of the SMI definition include. The SMI definition includes patients with some diagnosis such as psychosis, post traumatic stress disorder, substance abuse and other conditions, very specifically delineated diagnosed according to codes, instruments, et cetera et cetera. Those are the definitions of serious mental illness, major depression, et cetera.

So that is what the committee addresses. And I must say, in a population such as the VA, that is a significant contingent of patients that fall into the category of SMI. There are also other rules that have to do, for instance, with an intensive case management

approach, which also has other rules for what kinds of patients are to be included in the intensive case management program or assertive community treatment approach. So those are rules or definition.

In terms of from the clinicians' perspective, mental illness and serious mental illness are considered perhaps one being the overall mental illness which goes from a mild reactive depression, so-called dysthymia, which is in response to some environmental factor or loss, et cetera, which after a couple of months can fade away, but that is a mental condition that at the time may require treatment. By the same token, it goes in different levels of gradation, severity, family involvement or lack of involvement, loss of social networks, loss of employment, and that adds up to the severity of the condition. In short, Mr. Chairman, mental illness is the big umbrella. Many people fall under that. We only see the tip of the iceberg in the veterans' population.

Chairman ROCKEFELLER. Let me ask my second question before I go to Mr. Armstrong. When I say the words "American family" I mean an extended family. That is not my mother, father, children, wife, me, et cetera, but the extended family. What percentage of American extended families have some form of mental illness? This is obviously a stigma-based type question, because I am angry like you both are because of the continued stigma of mental illness. Sometimes it is classic American behavior to deny what sits right in front of your face. But what is the answer to my question?

Dr. ALARCÓN. I would have to answer with what epidemiological research gives us, namely that every epidemiological study in the community, which includes of course families and family units, report at least 25 percent of the population with some kind of diagnosable——

Chairman ROCKEFELLER. So it is 25 percent of the population.

Dr. ALARCÓN. Yes.

Chairman ROCKEFELLER. That almost means every extended family, does it not?

Dr. ALARCÓN. I would say so.

Chairman ROCKEFELLER. So that is something we need to think about.

Dr. ALARCÓN. I would—they are saying yes, Mr. Chairman. And I think there is a significant support in different epidemiological studies in the last two or three decades, studies that include the recent, mid 1990's, the National Community Health Survey, the NCHS. And those show really the prevalence of mental illness across the spectrum of the American population, and the fact that conditions such as depression will be in 20 or 30 more years at the top of the disability factors in this country.

Chairman ROCKEFELLER. Thank you, doctor.

Mr. Armstrong?

**STATEMENT OF MOE ARMSTRONG, DIRECTOR OF FAMILY AND CONSUMER AFFAIRS, VINFEN CORPORATION, REPRESENTING THE NATIONAL ALLIANCE FOR THE MENTALLY ILL**

Mr. ARMSTRONG. Thank you, Mr. Chairman.

My name is Moe Armstrong. I served with the Marine Corps, Third Reconnaissance Battalion in Vietnam, 1965, 1966. And on my way up here I was in Southwest Virginia, and I picked up a friend of mine who served with me in Vietnam. I would like to acknowledge him also. Bill Mulkiat served in Vietnam. He is from Harlan, Kentucky, drove over the mountains, and we came up from Abbington, Virginia to be here. It is an honor to be here.

Chairman ROCKEFELLER. Well, you are an honorary citizen of Southern West Virginia, by definition of where you come from.

Mr. ARMSTRONG. 75 people I have trained to do support groups down in Southwestern Virginia, as matter of fact, up to Bluefield where you are.

In 1965 I kept breaking down. I was a Special Operations soldier. I could not believe this had happened to me. I had been trained as a medical corpsman to treat people for a sucking chest wound. I had been trained to do all kinds of medical interventions, and I did not know how to treat people, and including myself, for mental illness, and that was very devastating for me.

I was evacuated to the Navy hospital in 1966 and released to the streets. And in those days you were either in the hospital or you were on the streets, and I immediately became homeless and moved to New Mexico, where I lived for 3 years in little shacks and tents, and lived marginally with help from town and food stamps. At that time the New Mexico Veterans Service Commission and the Veterans Administration picked me up. I am very grateful because I could have died. I was one of those people that is extremely disabled by my own psychiatric condition.

So I went from being a tough Special Operations soldier to somebody who was homeless and a derelict really on the streets of America. From a Presbyterian Sunday School teacher to somebody who just almost could not even fend for themselves, and I could not believe this had happened to me.

And still this is happening. For me mental illness never went away. There is no cure. There is no miracle out there. But we can learn to live with mental illness. And I think that that is what is the great challenge in front of the Veterans Administration today. I do not necessarily think it is how much we have but we necessarily do. There is a practice called psychiatric rehabilitation, psychosocial rehabilitation. It seems as though those of us who have a major mental illness, and I have been blessed to have both post traumatic stress disorder and schizophrenia, lose social adeptness. Just as a person that had a physical disability would lose range of motion, we lose range of social interconnectedness with people. To develop that back takes skills. Those skills need to be psychiatric rehabilitation skills in practice. Most people have not been spending time learning this. Agreed, Fred and I have just done a video across the Veterans Administration, but I still get my care at the VA. My social worker, I have spelled her out, how to do psychiatric rehabilitation so she can work with me. I learned psychiatric rehabilitation skills, and I work in the State Mental Health Authority in the State of Massachusetts, and we have 35 support groups going in there, not for other people but also for my own well being. Having a mental illness means I have to spend the

rest of my life doing self maintenance and self monitoring. This is not an easy condition to live with.

Psychiatric rehabilitation is very practical in nature. It provides people with employment opportunities and provides people with planning for services, linking to services and keeping people in services. That is very different than counseling and therapy, talking about how do we feel. You know, we need to learn what we have and how to live with it. But it does have a vacuum that I would like to point out.

I feel as though peer support, which is something that I have gradually over the years developed, over the past 7 years in Massachusetts, is a real missing component for two reasons. First off, knowledge base. Those of us who have these conditions, I believe, can go back and be of service to teach other people how to live with these conditions so that we do not continuously fall apart, so we do not put our family through this mess that we experience internally and sometimes externally with this mental illness. Also we have—and I believe this—a moral responsibility to go back and work with those that are not doing well. Your Committee, through the Veterans Administration, put a lot of care into me through funding the Veterans Administration. What I got and who I am today I did not do on my own. I got this through a lot of care and a lot of support through the years, and I hope that it was money well spent and well funded through the VA. But you know what? I need to do that for other people. I have a moral responsibility to go back and work with those that are not doing as well, to make sure that they are able to be sane, stable, safe and sober, the four S's. If we do not do peer support, our staff cannot spend all of its time working with us that have these conditions. These conditions are very labor intensive. I can burn out 5 psychiatric nurses in an afternoon if I get on a roll, OK? [Laughter.]

This is like big-time stuff. It takes a lot of folks to cool me out. The best, I think, crisis prevention, is a lot of education up front. That education needs to be both peer support and professional support, and some peers and professionals working together. That is where I think we need to go in the Veterans Administration. We have not done a very good job of it. In Massachusetts we are attempting to do this. The State of Virginia is doing a fairly good job of this with their Medicaid waiver. Right now my job is working in different states besides Massachusetts. So I kind of also get an idea of where different states are in their growth and development with psychiatric rehabilitation.

You know, I really want to take the time to thank everybody for inviting me here today because I never dreamed that I would have this opportunity to work in mental health or have a job. As a matter of fact, it is very strange being with Bill who served with me in Vietnam because he remembers what it was like before I was homeless, before I was destroyed from mental illness, and how I have had to building my life back. This is not easy. We have a job ahead of us, but until we start to set up, I think, some levels of competency for psychiatric rehabilitation within the VA and start to set up, I would even encourage, through the compensated work therapy teams, the recruitment, training and development of other veterans with major mental illness to gradually go back and work

on our own system. I think we are always going to be picking up pieces and putting out fires and taking care of crises, rather than educating people up front.

I would like to thank you for inviting me and I want to leave you some of the buttons that we made for our Vet-to-Vet program. We are doing this in West Haven, and it is being evaluated by one of the MIRECC's. It is called Vet-to-Vet. The little logo I drew. And it is, "Gladly teach, gladly learn," and that is the motto of this program, gladly teach and gladly learn, because to be a good teacher, I really think you have to be a good learner.

Thank you.

[The prepared statement of Mr. Armstrong follows:]

PREPARED STATEMENT OF MOE ARMSTRONG, DIRECTOR OF FAMILY AND CONSUMER AFFAIRS, VINFEN CORPORATION, REPRESENTING THE NATIONAL ALLIANCE FOR THE MENTALLY ILL ON BEHALF OF THE NATIONAL ALLIANCE FOR THE MENTALLY ILL

Chairman Rockefeller, Senator Specter and members of the Committee, I am Moe Armstrong of Cambridge, Massachusetts. I am pleased today to offer the views of the National Alliance for the Mentally Ill (NAMI) on the Department of Veterans Affairs ability to deliver quality mental health care to veterans with severe mental illnesses. Specifically, I would like to address the programs necessary for recovery in the VA system as well as other best practice models and how they are being delivered to our nation's veterans.

In addition to serving on the NAMI Board, I am a veteran myself and I also was once homeless. I was a medical corpsman attached to Third Reconnaissance Battalion of United States Marine Corps; I spent almost eleven months in Vietnam. We were in combat almost every other week. I never flinched. I never ran under fire. Then, one day I became mentally ill.

I spent many months on the streets of America. I was trying to hold jobs and trying to stay in apartments. I kept breaking down on the job. I kept losing apartments. I would either be on the streets sleeping in the park or staying with friends till they got tired of me. This was 1966, nobody knew that much about mental illness or substance abuse. There was no after care from the hospital. I was alone to flounder and fall down. I applied to the Veterans Administration for help. At the time, I was living in a tent in over a foot of snow when representatives from the VA came up in the mountains to see me. They cried when they saw my condition. I was dirty and disoriented. I had no home. I was just surviving on some unemployment money that I had saved and food stamps. They got me connected with VA benefits and an agency called the New Mexico Veterans Service Commission. The VA and the New Mexico Veterans Commission helped me. They saved my life by bringing me out of homelessness. They got me psychiatric care. They got me educated and working. Today, I help others living with mental illness—I work in the mental health field so that I can recreate for other people the opportunities I received from mental health care. I also currently serve as a member of VA's Consumer Liaison Committee on Care of Veterans with Serious Mental Illness Veterans.

#### WHO IS NAMI?

NAMI is the nation's largest national organization, 220,000 members representing persons with serious brain disorders and their families. Through our 1,200 chapters and affiliates in all 50 states, we support education, outreach, advocacy and research on behalf of persons with serious brain disorders such as schizophrenia, manic depressive illness, major depression, severe anxiety disorders and major mental illnesses affecting children.

NAMI believes that while treatment is central to recovery, it is not an end in itself. Housing, psychosocial rehabilitation and supports provided by agencies such as VA play a critical role in this process. NAMI is therefore pleased to offer our views on the VA's ability to provide the services and supports necessary for recovery.

#### VHA CAPACITY TO TREAT VETERANS WITH SEVERE MENTAL ILLNESS

The Independent Budget reports 454,598 veterans have a service connected disability due to a mental illness. Of great concern to NAMI are the 130,211 veterans

who are service connected for psychosis—104,593 of whom were treated in the VHA in FY 1999 for schizophrenia, one of the most disabling brain disorders.

NAMI feels strongly that the VA must do more to maintain capacity for veterans with severe and chronic mental illness. NAMI applauds this Congress for reinforcing the capacity law through the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (PL 107–135). This law strengthens the VA's capacity to serve veterans with mental illness, requiring improvements to the current system to ensure that veterans have access to necessary treatment and services. The new law not only requires the Department to maintain capacity for serving veterans with mental illness but also replace lost capacity.

The Committee on the Care of Veterans with Serious Mental Illness (SCMI Committee) reports that during FY 2002 VHA spent only 77% of the amount that it spent in FY 1996 for care of veterans with serious mental illness—a decrease of \$478 million annually. (This was based on data from the FY 2002 Report to Congress on Maintaining Capacity for Special Populations). This reduction is despite mandates that the VHA focus on its high priority veterans, including veterans with serious mental illness.

NAMI supports the FY 2003 Independent Budget recommendations for increasing the VHA's capacity to serve veterans with mental illness—including recommending that to simply achieve parity with other illnesses, the VA should be devoting an additional \$478 million to mental illness spending.

#### THE VHA'S MOVE FROM INPATIENT TO OUTPATIENT TREATMENT

Mr. Chairman, in NAMI's opinion, the lack of access to treatment and community supports for veterans with severe mental illness is among the greatest unmet need of the VA. Over the last five years the VHA has shifted its focus of serving veterans with severe and chronic mental illness from inpatient treatment to community based care. From FY 1994 to FY2001 the number of veterans receiving inpatient treatment for severe mental illness has dropped from 58,062 to 35,888. NAMI strongly supports treating veterans with severe mental illness in the community when the proper intensive community supports and treatment are available and easily accessible. However, we are very concerned that those veterans who need inpatient care are increasingly unable to access needed treatment because of the limited inpatient beds, and the dramatic shift to outpatient treatment.

NAMI is extremely grateful for the leadership Congress, and especially this Committee, has provided in holding the VA accountable for its inability to ensure that savings derived from the closure of inpatient psychiatric beds is transferred into community-based treatment services. The VA should not be allowed to make the same mistakes that so many states and communities have made over the past quarter century with respect to deinstitutionalization. Numerous studies have demonstrated that in states all across our nation dollars saved through the closing of state psychiatric hospitals were either never transferred into the community, or squandered on community-based services that lacked focus and accountability. The VA's Committee on Care of Veterans with Serious Mental Illness (SCMI committee) reports that from FY 1996 to FY 2001 of the 43% or \$600 million total reduction in inpatient dollars, only 18% or \$112 million of these savings were reinvested in expanding community support programs during this period. From NAMI's perspective, it is obvious that this significant decrease in inpatient care has not resulted in a sufficient transfer of resources to community-based treatment and supports for veterans with severe mental illnesses.

Mr. Chairman, because of the influx of lower priority veterans (Category C) into the VA health system, many resources are now going to towards the care of an ever increasing group of veterans and away from special populations. The SCMI Committee reports that from FY 1996 to FY 2001 there has been an increase of 568% in the number of low priority Category C veterans who are now coming to VA for what seems the prescription benefit. With only 23% of costs for Category C veterans being reimbursed by insurance—this has had a net cost to the VA of \$747 million in FY 2001 for Category C veterans. NAMI fears that many resources saved from the closure of inpatient beds have not been effectively reinvested in community services, but rather for care of the growing population of Category C veterans. NAMI believes that while all of our nation's veterans deserve quality care, it should not come at the expense of high priority veterans living with severe mental illness.

NAMI would continue to urge this Committee to specifically direct the VHA to require that all savings from cuts in inpatient psychiatric beds be reinvested in providing a continuum of care for veterans with severe mental illnesses.

## RECOVERY FOR VETERANS WITH SEVERE MENTAL ILLNESS

The Department of Veterans Affairs offers several specialized programs aimed at assisting veterans live healthy, productive lives in the community. Access to programs providing outreach, rehabilitation and supported housing are critical for veterans with severe mental illness. Mental Health Intensive Case Management (MHICM) can also be a very effective service for veterans with acute care needs. The VA also offers specialized services for PTSD and substance abuse—however these programs must be expanded to meet the needs of veterans receiving VA health care.

## HOUSING

As you know, housing is the cornerstone of recovery from mental illness and a life of greater independence and dignity. In my work over the years in peer counseling and training consumers to work in the peer counseling field, I have witnessed first-hand the central role that decent, safe and affordable housing plays in promoting recovery, access to treatment and a stable life in the community. NAMI believes that no single program or model can meet the needs of every individual living with severe mental illness. NAMI feels strongly that range of options are needed for consumers based on their own circumstances—from supported housing to congregate living to tenant-based vouchers to homeownership—a range of options supported through VA's programs are needed. The VA also needs work more effectively with HUD to ensure that veterans with severe mental illness have access to all of HUD's affordable housing programs. This is especially necessary for homeless veterans that desperately need access to permanent supportive housing programs funded under the McKinney-Vento Homeless Assistance Act such as Shelter Plus Care.

## MEDICATIONS

NAMI members strongly support research to discover a cure for severe brain disorders. Until then, more than anyone else, NAMI consumers and families recognize the need for medications that can control the symptoms of these brain disorders. Our nation's veterans must have access to the best medications for their illness.

NAMI believes that professional judgment and informed consumer choice should determine the choice of medications. Choice of treatments should be based on our knowledge of effectiveness and side effects and should be consistent with science based treatment guidelines, not solely on cost. NAMI members are committed to work to identify and remove any barriers that prevent persons with severe brain disorders from receiving the right medication, at the right dose, at the right frequency, and for the right duration. NAMI believes that the right medication is not only right for the veterans but it is also right for VA health system—there is growing evidence that access to newer medications may reduce the total cost of the illness by reducing other medical expenses such as hospitalization, by improving compliance, and by reducing disability.

## VOCATIONAL REHABILITATION

Research has shown that those who receive psychiatric rehabilitation are more likely to return to work, school and a productive life and are significantly less likely to be hospitalized. However, many veterans with severe mental illness do not receive the necessary vocational rehabilitation and employment services that will allow for transition into the workforce. The VHA has many programs that offer beneficial services for veterans looking to reintegrate into the community; however VHA must do a better job at outreach to disabled veterans. Further, many of VA's vocational rehabilitation policies must be updated and include increased integration of evidence based programs and supports. The VA's programs should also be reformed to more effectively provide ongoing job-related supports that help veterans with mental illness stay in a job, not just get a job. Pre-employment services are only as effective as the ongoing on-the-job supports provided over the long-term.

Compensated Work Therapy (CWT) is a VA program that uses work therapy to help veterans re-enter into the community by assisting veterans learn important work skills, earn money, and more importantly improve the quality of their lives through employment. NAMI feels that this is a best practice model and a rehabilitative program that should be further expanded to allow more veterans access to employment opportunities. In FY 2000, 46% of veterans who completed a CWT program were placed in competitive employment and another 8% were placed in other training programs. Unfortunately, while research demonstrates that people with severe mental illness want gainful employment, less than 1% of the 82,000 veterans with psychosis under the age of 50 participate in the CWT program. Further, each

dollar that is spent in providing CWT services returns an average of two dollars in earnings—remaining revenues (currently around \$10 million) should not be left to sit in a VA account but should be used to help veterans continue to work with the necessary supports in place. Not only is VA missing an opportunity to expand community-based rehabilitation options for veterans, but veterans with severe mental illness are not adequately provided the opportunities to access supported employment. VA must do a better job in implementing best practice models into the community.

NAMI recommends that Congress amend Title 38, section 1718(b) of the United States Code to allow VA to offer veterans in the CWT program such important services as job coaching, vocational placement and ongoing support services necessary for veterans to maintain employment. Congress should make the CWT program more effective and responsive to veterans with mental illness by allowing increased financial flexibility of current funds to be used to provide rehabilitative training and other support services to help veterans gain and maintain employment. NAMI also recommends that Congress require VA to report regularly on the number of veterans with referrals for therapeutic work-based rehabilitation, the number of veterans accessing CWT and the effectiveness of the program in implementing evidence based practices.

#### PSYCHOSOCIAL REHABILITATION

Psychosocial rehabilitation is another key element to a continuum of care for veterans with severe mental illness. Psychosocial rehabilitation is part of a comprehensive approach in providing support, education, and guidance to people with mental illnesses and their families. Studies tell us that psychosocial treatments for mental illnesses can help consumers keep their moods more stable, stay out of the hospital, and generally function better. Peer educational supports should be a part of psychiatric rehabilitation services.

#### PEER SUPPORT

The concept of recovery is a self-help philosophy that is the future of mental health care. Consumers in recovery with experience and knowledge of the psychiatric condition—and its concurrent social realities—are the people who are able to most effectively help their peers recover. My wife and I founded the Peer Educators' Project and this project believes that people who have a major mental illness or psychiatric condition are a resource to learn from. We have over forty-five educational peer support groups across the Commonwealth of Massachusetts and employ over fifty people. We are now working with the VA in both Bedford, Massachusetts and West Haven, Connecticut in setting up Peer Educator support meetings—this program is called Vet-to-Vet and “Gladly-Teach, Gladly-Learn” is the motto. Currently, the VA's Northeast Program Evaluation Center in New Haven, CT is conducting a multi-year evaluation of the Peer Educators Project in VISN 1.

We are educators. But initially we are students in need of some information. So, the Peer Educators Project spends time reading books like the Recovery Workbook from the Boston University Center for Psychiatric Rehabilitation, authored by Martin Koehler and LeRoy Spaniol. We also read current articles about mental illness and the mental health system. We are also a source of information for one another. We think about what has happened to us and how or why we ended up in the mental health system.

The Peer Educator model is designed to address three goals: (1) To educate people with mental illnesses on services, medications, their rights to make treatment decisions, and to identify barriers to recovery, (2) To assist people with mental illnesses focus on recovery and rehabilitation via role models and an expectation that people take responsibility for their own lives and decisions, (3) To create social and community connections to counter social isolation and create one's own healthy, natural community supports.

There have been some misunderstandings during our time in the mental health system. There are also some valid reasons why we are in and continue to stay in the mental health system. We need to learn about the psychiatric condition that we have and pass that information on to other people. We are trying to learn about our anxieties, sleeplessness, depressions, and wild behaviors that got us into the mental health system. We need to learn about what we have and how coping day to day with ordinary life and mental illness is possible.

We also learn and teach each other how to pick up on the subtle signs of the onset of psychiatric crisis. We talk to each other frankly and openly about what has happened and continues to happen to us. There is nothing wrong in being mentally ill. However, there is something wrong in not having supporting and caring mental

health systems that provide care. Many veterans with psychiatric conditions need long term care and assistance—care that is provided by people working with people and consumers working with consumers.

#### CONSUMER COUNCILS

The Fourth Annual Report to the Under Secretary for Health submitted by the Committee on Care of Severely Chronically Mentally Ill Veterans dated February 1, 2000 stated in recommendation 9.1: "Networks should redouble their efforts to establish mental health stakeholders councils at all VHA facilities and at the Network level. Progress in establishment of such councils should be monitored and considered in the evaluation of key officials."

NAMI continues to fully support the implementation of Mental Health Consumer Councils and the recommendation by the SCMI committee. At the VISN level, Mental Health Consumer Council brings together consumers, family members, Veterans Service Organizations, and community agencies that can discuss services, policies, and issues which are important to veterans receiving treatment for mental illness. Approximately half of the VISNs have Mental Health Consumer Councils, but full participation by all VISNs is still needed.

#### HOMELESS VETERANS

As you know, severe mental illness and co-occurring substance abuse problems contribute significantly to homelessness among veterans. Studies have shown that nearly one-third (approximately 250,000) of homeless individuals have served in our country's armed services. Moreover, approximately 43% of homeless veterans have a diagnosis of severe and persistent mental illness, and 69% have a substance abuse disorder. NAMI strongly supports provisions that would mandate evaluation and reporting of mental illness programs in the VA and that veterans receiving care and treatment for severe mental illness be designated as "complex care" within the Veterans Equitable Resource Allocation system. Moreover, NAMI feels that language providing for two treatment trials on the effectiveness of integrated mental health service delivery models would be very beneficial in identifying best practice in serving and treating veterans with severe and persistent mental illness within the VA. Our nations veterans with severe mental illness should be in treatment and not on the street.

#### CONCLUSION

Thank you Chairman Rockefeller for allowing me the opportunity to testify before the Committee on the services and supports veterans with mental illness need from the VA to live full and productive lives in the community. I never dreamed that thirty-five years ago I would be able to go to school, hold a job, and come to Washington to speak before you, it is a testament to the impact VA services can have on a veteran. Thanks again for all you do on behalf of veterans with severe mental illness.

Chairman ROCKEFELLER. Extraordinarily articulate.

Mr. ARMSTRONG. Thank you. Not for everybody.

Chairman ROCKEFELLER. No, but that was good. What you said was so powerful. Actually I think that the testimony belittles questions that I might ask. I am going to send some to you.

Mr. ARMSTRONG. Thank you.

Chairman ROCKEFELLER. But I want to end this with a question, just one question to you, Mr. Armstrong, and also you, Dr. Frese. And that is again the family aspect of this. We have talked this morning about maintenance as opposed to improvement and curing, and that you cannot do either until you know that you have a problem. And you either know you have a problem and then seek treatment, or a family member coaxes you, and encourages you to getting treatment if they are so disposed or you have an episode of some sort. You spoke of your homelessness in New Mexico. And then somebody reaches out to you, and help begins that way.

But the point is that what you care about and what is evident in you is not just maintenance, but getting better. Now, you said there is no silver bullet, and everybody understands that, Doctor

Alarcón, you indicated sometimes mental illness will be there for a while and then it will disappear. And in many, more cases, it will be there and it will not go away. But it can get better. And if somebody, no matter what their condition, feels they are getting better, am I wrong to say that that can almost come somewhere close to feeling like you are about to be cured?

Dr. ALARCÓN. Exactly, Mr. Chairman. I think in psychiatry and clinical psychiatry now, unfortunately, we cannot speak of a cure, but we can speak of improving significantly the functionality, the ability to interact with the social environment and the quality of life, and I think psychiatry and medicine have made a lot of progress into that and for people like Mr. Armstrong and Dr. Frese, the benefits are evident.

Mr. FRESE. And part of that quality of life has to be quality of integration into the greater society. We can no longer be isolated. And our families—I just did a thing for “Nightline”, and one of the cameraman came up to me afterwards and said his father had psychosis all of his life—he was in tears—he said he could never talk about it at all. That is beginning to change. We are beginning to lift this veil of stigma, and with your help, we will be doing that in the VA as we are elsewhere. Thank you.

Mr. ARMSTRONG. My own family was very devastated by this. They were poor people from the rural part of Illinois. For them the military was their ticket, my ticket. They are retired janitors. I became mentally ill and was lost in America for a long time. There was too much time lost. I think that through education—and I am a big believer in education as opposed to traditional therapies—understanding what is mental illness, teaching people what we know about the mental health system. It is just as difficult understanding the mental health system and how it operates, mental illness. By setting these constructs up where the family comes in and receives education, not just family therapy, I think we can go a—and the veteran starts to receive this, both professional and peer education, I think we can get along way toward becoming sane, stable, safe and sober. Those are my S’s. That is what we should be reaching. I do not think there is a silver bullet, but we can get sane, stable, safe and sober. And the only way I know how to do it is educationally.

I would suggest that the mental health system of the future, it will probably look a lot more like an old-fashioned one-room schoolhouse than the clinical settings that we have today, and this ongoing educate, educate, educate, learn, learn, learn, teach, teach, teach, will be more of a construct. That is the ultimate stigma reduction, I think, when it just becomes like any other illness, and we just start to train people how to live with it and what we have.

So that would be my take on it. Thank you, Senator.

Chairman ROCKEFELLER. I thank all of you. I wish that all of America had watched every moment of this hearing. We would all be better for it.

Thank you all.

[Whereupon, at 11:35 a.m., the committee was adjourned.]



## APPENDIX

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PREPARED STATEMENT OF HON. BEN NIGHTHORSE CAMPBELL, U.S. SENATOR FROM  
COLORADO

Thank you, Mr. Chairman. I appreciate your convening today's hearing to examine the current range of mental health services being provided to our veterans. This is a very serious issue and I am pleased that the committee is focusing on it. I would also like to welcome Under Secretary Roswell and the others who are here to testify today.

As we enter another year of limited funding for veterans health care, we are still being reassured by the VA that quality care for our veterans will not only continue, but will improve. Based on the feedback from many of our veterans, however, I am beginning to question this assertion. Like my colleagues, I am concerned that the VA respond satisfactorily to our veterans who need specialized care such as mental health services.

Recently, the VA announced plans to overhaul its health care system. It will attempt to change the focus to outpatient care and get services closer to the people who need them. An independent nine member panel will make recommendations on where to cut and where to add.

And, I understand that the VA is looking at new models that would integrate primary health care into the care of mental health clinics. Some studies find that individuals accessing medical care through mental health clinics receive a better quality of primary care and their health status is improved over time. The costs, I am told, are similar.

But, all the while we say we are improving services by focusing on outpatient care, we seem to be cutting services for those who need mental health services.

Over the past several years, the Veterans Health Administration has reduced funding for critical mental health services in an effort to reduce over all costs. Regionally, some VISNS (Veterans Integrated Services Network) have implemented restrictions on anti-psychotic drugs based on cost. I believe that reducing access to life-saving medications for our nation's veterans and cutting back on mental health services in particular are misguided attempts to reduce treatment costs.

And, in my state of Colorado, under VISN 19, it is my understanding that though a number of mental health facilities and services are available, the veterans are having a hard time getting certified to receive those services.

The wounds of war are not always visible. In the aftermath of war time combat, a great number of people have been affected and they have been, and are, affected in a great many different ways. Their needs vary with the type of trauma they experienced.

While I commend the VA for the advances it has made to date in its broad policy goal of serving more veterans in outpatient settings, I believe we must also focus on managing symptoms and ensuring supports outside of an institutional setting. If serving more veterans comes at the expense of those with specialized needs, the gains we have made thus far will be lost.

I hope that the members of this Committee, the VA and the VSOs can work together on this issue. We need to think creatively about how we can best serve our vets who need mental health services. No one wants to hospitalize people who no longer need it. But if we are to send our veterans out into the community, we need to consider a broad array of support services that can maintain people outside of institutional settings. Those vets who are facing problems because of their service to their country deserve no less than the best care we can provide.

Again, I thank you, Mr. Chairman, and look forward to today's testimony.

## PREPARED STATEMENT OF THE AMERICAN ASSOCIATION FOR GERIATRIC PSYCHIATRY

The American Association for Geriatric Psychiatry (AAGP) is pleased to have the opportunity to provide a statement for the record of Veterans Affairs Committee's hearing on Mental Health Care: Can VA Still Deliver? AAGP is a professional organization dedicated to promoting the mental health and well being of older Americans and improving the care of those with late-life mental disorders. AAGP's membership consists of approximately 2000 geriatric psychiatrists as well as other health professionals who focus on the mental health problems faced by senior citizens.

While we agree with others in the mental health community about the importance of Federal support for mental health research and treatment, AAGP brings a unique perspective to these issues because of the elderly patient population served by our members.

This Committee has provided important leadership in the effort to provide the highest quality health care for our nation's veterans and for the research necessary to advance the quality of their care. AAGP strongly supports S. 2044, which would continue and increase funding of specialized VA mental health services programs for post traumatic stress disorder (PTSD) and substance abuse disorders. AAGP also welcomes the introduction of legislation to increase the number of VA centers for mental illness research, education, and clinical activities. Our nation's veterans put forth their lives for our nation during times of war, and they deserve access to quality health care in times of peace.

## THE CHALLENGE OF MEETING THE MENTAL HEALTH NEEDS OF THE AGING VETERAN POPULATION

AAGP is extremely concerned that the mental health needs of our aging veteran population is not being adequately met by current resources; and that the gap between needs and resources will widen rapidly unless Congress acts to increase support for veterans' mental health care, with an emphasis on older veterans.

Of our nation's 25.5 million veterans, 9 million, approximately 35 percent, are seniors who served in World War II or the Korean War. More than half a million veterans are 85 years of age or older, and the VA predicts that this oldest group will grow to 1.2 million by 2010. It has been estimated that between 35 percent and 40 percent of VA patients need psychiatric care, and those who are older often suffer from co-existing medical conditions such as heart disease, hypertension, diabetes, lung disease, debilitating arthritis, or other conditions. For these patients, treatment of their medical illnesses is often complicated by psychiatric disorders. Conversely, their psychiatric care is more complex because of the co-occurrence of medical illness, which commonly requires treatment with multiple medications. Thus, for older veterans with mental health problems, psychiatric treatment must be an integral component of their health care, and must be well-coordinated with the care they receive for other medical conditions.

Between the years 1990 and 2000, the number of veterans in the 45-54 year old age group who received mental health services from the VA more than tripled. These are the baby boomers who are now beginning, and will continue, to swell the ranks of those who require geriatric care. However, the most rapid growth in demand during the last decade was among the oldest of older veterans. During the last decade, there was a four-fold increase in the number of veterans aged 75-84 who received VA mental health services.

Despite the increasing need for coordinated mental health services for growing numbers of older veterans, funding for VA mental health services, training, and research remains disproportionately low throughout the VA system. Overall, the proportion of VA spending for mental health care has decreased by 23 percent since 1996. Although more than a third of veterans need psychiatric care, less than 9 percent of VA funds available for residency training were designated for psychiatric residency training in FY 2002. Of the \$409 million slated for medical and prosthetic research in President Bush's FY 2003 budget proposal, only \$36 million, or 8.8 percent, is earmarked for psychiatric research. This level of support for psychiatric services, training and research is disproportionate to the needs of the veteran population.

## PRESIDENT'S FISCAL YEAR 2003 BUDGET PROPOSAL

According to President Bush's budget recommendation for the Department of Veterans Affairs for FY 2003, approximately \$25.6 billion of the \$56.6 billion proposed for the Department would go to medical care programs, an increase of approximately \$2 billion. It is commendable that most health programs would receive a boost in spending under the President's budget proposal. For example, outpatient

care would receive \$12.5 billion, an increase of \$1.4 billion, while the nursing home care budget would increase to \$2.2 billion, a gain of \$118 million, and medical research programs would receive \$409 million, a \$38 million increase over current spending. However, AAGP is alarmed that these increases would be offset by cuts in mental health and residential care programs. The President's proposal would require the VA to achieve more than \$300 million in unspecified "management savings," requiring a staffing reduction of some 800 employees. Historically, mental health programs are the first to suffer when ill-defined cuts are imposed. And because the complex care so often needed to maintain the older patient's independence requires more—not less—comprehensive, integrated mental health and medical management, "savings" in this area will likely lead to greater dependency.

Given that the VA health care system, and particularly its psychiatric and substance abuse programs, have sustained deep cuts in recent years, the Administration's budget proposal spells trouble. Last year saw the enactment of the "Homeless Veterans Comprehensive Assistance Act of 2001" that requires the VA to assure mental health services in every VA facility, and the "VA Health Care Programs Enhancement Act of 2001" that directs the VA to expand substantially the number and scope of specialized mental health and substance abuse programs it operates so as to afford veterans real access to needed specialized care and services. Apparently ignoring these statutes, the President's budget offers no plan for restoring lost capacity in VA mental health care and substance abuse programs; instead, it continues the reductions that have become the norm in recent years. Continued cutbacks will seriously jeopardize veterans' mental health services, and will take a serious toll on older veterans. Rather than offering improved access to care, this budget, if enacted by Congress, would reduce health care staffing and increase barriers to access for veterans. And to which system do we direct elderly veterans diverted from the VA when Medicare, Medicaid and state programs are no less constrained by budgetary shortfalls? There is no safety net. Elderly veterans with mental illness are especially vulnerable because employer-sponsored health plans and Medicare HMOs have limited mental health coverage and continue to reduce and eliminate drug benefits.

#### COMPREHENSIVE, INTEGRATED MENTAL HEALTH CARE FOR AGING VETERANS

Mental health treatment must address the special needs of those older veterans with concurrent psychiatric disorders, medical illness, and substance use disorders, as well as those with severely debilitating psychotic disorders and post-traumatic stress disorder (PTSD). According to the Veterans Administration, of the 455,000 veterans suffering from a service-connected mental disorder, more than 130,000 have chronic, severe psychotic disorders such as schizophrenia, and approximately 130,000 have PTSD, conditions that often have emerged or were aggravated during time in the service. PTSD is often directly related to combat duty. Surely those veterans should be afforded services of the highest quality, with access to a comprehensive continuum of care that defines state-of-the-art mental health treatment.

AAGP believes that the range of integrated services within the hospital and upon discharge to the community that is provided to veterans with mental disorders should serve as a benchmark for health care services in all public and private health care systems in our country. Older veterans with co-occurring medical and psychiatric disorders, often complicated by alcohol or drug abuse, require access to a well-integrated system of services. For those veterans with serious mental illness, state-of-the-art care for severe mental illness is recovery-oriented, rather than dependency-oriented, as documented in the U.S. Surgeon General's Report on Mental Health (1999). Such recovery requires an array of services that includes intensive case management, pharmacological treatment, access to substance abuse treatment, peer support and psychosocial rehabilitation such as housing, employment services, independent living and social skills training, and psychological support. Within this continuum of services, Readjustment Counseling Service Vet Centers are a community-based component that provides veterans with counseling for psychological war trauma, using an interdisciplinary team approach. With the growth of the aging veteran population, which includes Vietnam-era veterans, AAGP regards these Vet Centers as an important site for the provision of integrated geriatric psychiatric care over the next ten to fifteen years.

AAGP strongly recommends that the savings from the closing of VA inpatient mental health programs be reinvested in Community Based Outpatient Clinics and the development of an outpatient continuum of care that includes this array of services. In particular, AAGP urges support of Mental Health Intensive Case Management programs in community and home settings. Intensive Case Management is a vital element of care that is needed if the VA is to maintain the sickest patients

outside the hospital setting. By providing comprehensive, integrated medical and mental health care through Community Based Outpatient Clinics, and ensuring continuity of care across service sites through Intensive Case Management programs, veterans will receive the highest quality care, and further reductions in inpatient services and spending will be possible. VA mental health professionals have identified these as needs “that should be the target of developmental efforts in the coming years” (Report of the Committee on Care of the Severely Chronically Mentally Ill Veterans, February 2000, page 64).

Despite the outstanding advocacy of VA mental health professionals, the Department is still struggling to furnish this comprehensive spectrum of services to veterans with severe mental illness today. Unless the VA budget for psychiatric care is increased, barriers to providing the full spectrum of mental health services will inevitably increase. Enactment of S. 2044, which would expand and improve the provision of specialized mental health services to veterans, would constitute a significant step toward strengthening mental health services where they are most needed. AAGP has also recommended, in testimony before the Senate Appropriations Committee, that Congress incrementally augment funding for the care of seriously mentally ill veterans by appropriating an additional \$100 million both in FY 2003 and in FY 2004.

#### VETERANS AND ALZHEIMER’S DISEASE

AAGP would like to bring to the Committee’s attention the fact that an estimated 30 percent of the patients in veterans’ nursing home facilities suffer from Alzheimer’s disease or another form of dementia. As the elderly veteran population increases, the capability of the traditional veterans’ nursing home facilities to care for veterans with Alzheimer’s disease will be overwhelmed. The VA should encourage innovation in the methods utilized by VA health personnel in treating veterans with Alzheimer’s disease; and should also develop family and caregiver support programs to enable veterans to remain at home for an extended period, before nursing home care becomes necessary. AAGP recommends the creation of a new line of mental health research funding earmarked for the development, testing, and dissemination of interventions to manage the psychiatric manifestations and complications of Alzheimer’s disease and related dementias.

#### VETERANS’ ACCESS TO MEDICATION

AAGP is concerned about restrictions on the availability of those medications that are safer or better tolerated by elderly patients. Restricted access to such medications specifically discriminates against older veterans with mental illness who, as a result of the effects of aging, medical illness, and concurrent use of medications for the treatment of medical and psychiatric illnesses, are more susceptible to the potential adverse effects of medications. When safer, better-tolerated medications exist, they should be made available as first-line treatments and should not be subject to a “fail-first” policy. The current suspension of such a policy—which should be made permanent—is important in averting unnecessary suffering, especially in older veterans who are the most vulnerable to drug side effects.

#### RESEARCH AND MIRECCS

VA research on mental health remains under-funded. President Bush’s proposal to allocate only 8.8 percent of the VA medical research budget to psychiatric research is inadequate, especially for the VA health care system, in which 40 percent of patients have a need for mental health care. AAGP has recommended that Congress appropriate \$425 million for medical research, and earmark \$63 million of this for psychiatric research. This represents an increase of 15 percent over amount in the President’s proposed budget. As the elderly veteran population expands, and the number with mental illness grows, strengthening the research base in geriatric psychiatry becomes increasingly urgent. VA sponsored research into mental disorders of aging benefits all Americans, not just our veterans.

A vitally important VA program for coordinating mental health research with education and clinical care are the Mental Illness Research, Education, and Clinical Centers (MIRECCs). AAGP commends the Congress for funding eight VA MIRECCs across the country. AAGP believes the MIRECCs have successfully demonstrated that coordinated research and education projects can achieve rapid translation of new scientific knowledge into improved models for clinical services for veterans with mental illness. These programs should be continued. MIRECCs focus on problems highly relevant to veterans with schizophrenia, PTSD, and other serious mental illnesses, including those whose treatment is complicated by homelessness, substance abuse, or alcoholism. AAGP wishes to emphasize the value of those MIRECCs that

focus on issues related to aging, including dementia, and psychiatric disorders in older veterans with concurrent medical illness and/or substance use disorders.

#### CONCLUSION

In conclusion, AAGP commends this Committee for its concern and continuing efforts to assure adequate mental health services, training, and research in the VA system. It is important, in the face of continuing budgetary pressure, to stem the tide of reductions in mental health services. The reductions we have seen in recent years will undermine the provision of proper treatment not only to elderly veterans, but also to those who are currently young and middle-aged—a course that will lead to more severe problems later in life as their disorders become more complicated and difficult to treat.

